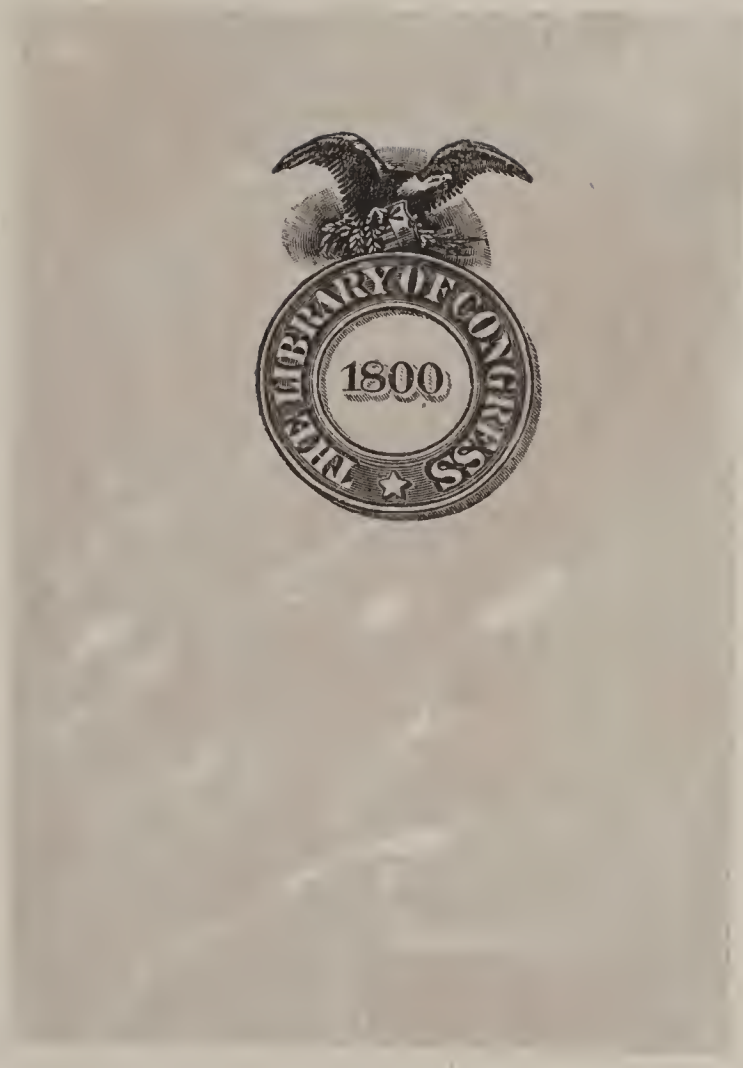
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MEDICAL STUDIES
on
MERCHANT SEAMEN
Number 1

TRAUMATIC WAR NEUROSES

CONFERENCE
JANUARY 28, 1943

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UNITED SEAMEN'S SERVICE, INC.

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Conference on Traumatic War Neuroses in Merchant Seamen, New York, 1943.

PROCEEDINGS

Conference on

TRAUMATIC WAR NEUROSES IN MERCHANT SEAMEN

THE MEDICAL PROGRAM

of the

WAR SHIPPING ADMINISTRATION (RMO)
and
UNITED SEAMEN'S SERVICE, INC.

Under the Guidance of
UNITED STATES PUBLIC HEALTH SERVICE

January 28, 1943

New York Academy of Medicine
2 East 103rd Street
New York City

From the Medical Department of the
War Shipping Administration (RMO)
and
United Seamen's Service, Inc.
Daniel Blain, Surgeon (R)
United States Public Health Service, Director.

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MEMBERS PRESENT AT THE CONFERENCE

United States Army Medical Corps

Brig. General DAVID N. W. GRANT — Col. ROY D. HALLORAN
Major JOHN M. MURRAY

United States Navy Medical Corps

Capt. A. A. MARSTELLER — Lieut. HOWARD P. ROME

Royal Navy Medical Corps

Surg. Comdr. R. W. MUSSEN

Royal Canadian Air Force

Flight Surgeon C. G. STOGDILL

Royal Canadian Navy

Surg. Lt. MERVIN WELLMAN

Royal Canadian Medical Corps

Brigadier G. D. CHISHOLM

Norwegian Public Health Service

Surgeon General KARL EVANG — Dr. WILLIAM HOFFMAN

U. S. Veteran's Administration

Dr. HUGO MELLA

U. S. Public Health Service

Surgeon General THOMAS PARRAN
Asst. Surgeon Gen. WM. F. OSSENFORT
Asst. Surgeon Gen. LAWRENCE KOLB
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P. A. Surgeon S. D. VESTERMARK
P. A. Surgeon (R) LESLIE H. FARBER
P. A. Surgeon R. N. FELIX
Acting Asst. Surgeon HAROLD KELMAN
Dr. BEATRICE BERLE
Dr. S. W. HAMILTON
Dr. TITUS HARRIS
Dr. JOHN MUSSER
Surgeon (R) EVERETT S. RADEMACHER

(Continued on next page)

Civilians

Dr. VIOLA BERNARD
Dr. EARL D. BOND
Dr. KARL BOWMAN
**Dr. RICHARD BRICKNER
Dr. A. A. BRILL
Dr. DEXTER M. BULLARD
Dr. C. C. BURLINGAME
Dr. C. MACFIE CAMPBELL
Dr. ROSS McC. CHAPMAN
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Dr. SANDOR RADO
Mr. ELMER ROESSNER (O.W.I.)
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Dr. GEO. S. STEVENSON
Dr. EDW. A. STRECKER
Dr. HARRY S. SULLIVAN
Dr. THEODORE A. WATTERS
Dr. JOHN C. WHITEHORN
Dr. DAVID WECHSLER
Dr. H. B. WILCOX
Dr. VERNON P. WILLIAMS
*Dr. S. BERNARD WORTIS

WSA (RMO) and USS

Mr. MARSHALL E. DIMOCK, Assistant Deputy Administrator, Recruitment and Manning Organization
Mr. DOUGLAS P. FALCONER, National Executive Director, United Seamen's Service, Inc.
Surgeon (R) DANIEL BLAIN, Medical Director
P. A. Surgeon (R) WILLIAM BELLAMY, Asst. Medical Director
Miss MADELINE OLDFIELD, Executive Assistant
P. A. Surgeon STEPHEN SHERMAN, Chief Medical Officer
Dr. GRACE BAKER, Chief Medical Officer
Dr. MARGARET DeRONDE, Chief Medical Officer
Dr. PAUL HENRY HOCH, Chief Medical Officer
Mr. NELS ANDERSON, Director, Service Division, R.M.O.
Mr. GEORGE L. WHITE, JR., R.M.O.
Dr. HOWARD POTTER, Medical Supervisor, New York

* Present in the afternoon
** Present in the evening

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INVITATION TO CONFERENCE

THE UNITED STATES PUBLIC HEALTH SERVICE has been collaborating with the United Seamen's Service and the War Shipping Administration in a program for the prevention and treatment of psychiatric casualties among merchant seamen, with special reference to the traumatic war neuroses. The plan has been in operation for several months and a considerable amount of very pertinent experience has been accumulated.

A definite procedure has been followed and several hundred patients have been treated. We have now arrived at the stage where it is felt that the general plan could be greatly helped by consultation with a few out standing physicians, including representatives from other government services. With this in mind I am extending an invitation to you to attend a conference at the Academy of Medicine in New York, on January 28, 1943, in order to discuss the various problems that have arisen and the possibilities for improving the program.

There will be an all day session, beginning at 9:30 in the morning. Those attending will be the guests of the Josiah Macy, Jr. Foundation at luncheon and at dinner. Expenses of travel will be paid by the Foundation.

I shall appreciate your letting me know that you will attend.

THOMAS PARRAN,
Surgeon General (U.S.P.H.S.)

INTRODUCTION

MEMORANDUM ACCOMPANYING INVITATION TO CONFERENCE

The distress of merchant seamen following bombing and torpedoing experiences led Rear Admiral Emory S. Land to request Surgeon General Thomas Parran to furnish the War Shipping Administration with doctors to provide help for those men. It was apparent that this program should fill the gap where the hospitals and clinics of United States Public Health Service left off—that convalescent and rest facilities were needed and that the great need was for treatment and prevention of the nervous conditions manifested by a very high proportion of survivors.

The work divided itself into three phases: Meeting survivors and providing emergency care for them as they returned to American shores; referring to appropriate hospital and clinic facilities those with medical and surgical conditions; and operating a series of centers or hospitals designed to care for those suffering from traumatic war neurosis.

The program developed is one wherein psychiatry predominates. The centers are open to somatic convalescents, but location, size, nursing care are all devised with the interests of victims of traumatic the general program of food, recreation and exercise, medical and war neuroses chiefly in mind.

The United Seamen's Service is shouldering an increasing amount of the responsibility for operating small units known as convalescent and rest centers. Five of them are functioning and if operated at a maximum capacity will take care of more than 4000 cases a year, giving each patient three weeks of care under what we consider the most ideal conditions for treatment.

CHIEF ASPECTS OF TREATMENT AVAILABLE TO ANY BONA FIDE MERCHANT SEAMAN

1. Free care with expenses partly paid by the War Shipping Administration,* and all resources of United Seamen's Service for personal service.

*The United Seamen's Service assumed a major share in the financing of the medical program as of July 1, 1943. By resolution of its executive committee and with the agreement of the War Shipping Administration, this step was undertaken by the United Seamen's Service in conformity with the purposes for which it was founded—THE EDITOR.

2. Rest centers limited to 50 men (preferably 35) in informal surroundings, rural atmosphere, quiet, with plenty of space, nearly always on salt water and no hospital atmosphere.
3. The head nurse is carefully picked for long psychiatric training in cases of psychoneurosis and mild anxiety states and both administrative and private-duty experience. No uniforms are worn. The head nurse is the house mother.
4. Great emphasis is placed on personal attention and food, with frequent feedings, ship's hours. The chef is an ex-shipsteward.
5. Medical treatment.

(a) Supportive: Food, rest, quiet, sedation, vitamins, personal attention, recreation, exercise, nursing care, occupational therapy.

Recreation in hands of local social committee that provides hostesses, games, entertainment, invitations, etc. All events must be approved by the doctor or nurse. Too much excitement and too much entertainment defeats our purpose.

Evidence of general good-will of neighborhood toward seamen and praise for their exploits are used as an emotional tonic.

(b) Direct psychotherapy: Personal interviews. First interview for history, catharsis and beginning of patient-doctor relationship—45 to 60 minutes. Thereafter, about three ten-minute private interviews a week.

Group talks and discussions. The doctor talks to the whole group two to three times a week on subjects pertaining to mental hygiene, anatomy, physiology, psychosomatic relationships, fatigue, sleep and rest. Nightmares, fear, anger and like topics are dealt with in straightforward simple language, avoiding all psychiatric terminology.

Traumatic war neurosis is called "war nerves;" the psychiatrist is the doctor; all treatment is medical; no psychotics are admitted; behavior problems which we cannot control are eliminated for the sake of the group; chronic alcholics and chronic psychoneurotics are refused admission except for special reasons.

Length of stay is now limited to three weeks. After the first four months, experience has shown that most men leave earlier and only those rapidly becoming chronic will tend to remain longer.

Staff psychiatrists are civilians in most instances, men or women whose experience has been with mild anxiety states

rather than with psychotics. We have been successful so far in persuading well-trained and leading psychiatrists to come in on a half-time basis as appointees of the United States Public Health Service because of the material available and the atttraction of a war job.

In all of the centers it has proved desirable to encourage a close working relationship with a leading school of medicine. This relationship is of advantage to our service as it tends to keep the professional work at a good level and to stimulate a research point of view; it is of advantage to the medical school because it has an important educational value. The following medical schools have formally sponsored one of our convalescent homes and have aided in securing psychiatric consultants from their staffs:

In order of their acceptance:
Long Island College of Medicine
Columbia University
Johns Hopkins University
Tulane University
University of California

The chief topics for discussion at this meeting are:

1. Etiology and Psychopathology of TraumaticWar Neuroses
2. Treatment of Traumatic War Neuroses.
3. Prevention of Traumatic War Neuroses.
4. General program to meet the needs in the American Merchant Marine.

DANIEL BLAIN, Surgeon (R),
United States Public Health Service

MORNING SESSION

INTRODUCTION

The Conference on Traumatic War Neuroses in Merchant Seamen, the Medical Program of the War Shipping Administration, Recruitment and Manning Organization, and United Seamen's Service, Inc., under the guidance of the United States Public Health Service, convened in the New York Academy of Medicine at 9:55 a.m. Eastern War Time, Surgeon General Thomas Parran, United States Public Health Service, presiding.

CHAIRMAN PARRAN: The conference will be in order.

I am very glad to welcome you colleagues here today to discuss an important medical war problem. We are glad to have representatives from the United States Army and Navy, and especially glad to have representatives from the Norwegian Government and from the Royal Canadian Army, Navy and Air Force.

In 1798 the Congress created the parent organization of the present Public Health Service to give medical care to merchant seamen. During the ensuing 145 years many other duties have been added but the care of merchant seamen has remained one of our important functions. The medical officers of the Service have had an unusual opportunity to study the characteristics and health problems of this industrial group. These seamen are a hardy group of people peculiarly adapted to the life they have chosen. They have an important responsibility in times of peace. The ships they man carry millions of tons of valuable cargo on long ocean voyages.

Since the outbreak of the present war, the responsibilities and hazards of the Merchant Marine have increased many times. The transportation of goods and implements of war to ports of the Allied nations and to our fighting forces abroad is of basic importance to our war effort. That the enemy should seek to cut our supply lines by all possible means is to be expected. The men of the Merchant Marine are in constant danger of attack on the high seas by enemy surface raiders and enemy submarines. How many merchant ships have been lost and how many seamen have been killed by direct enemy action or have lost their lives as a sequel of

this action cannot be stated even in this closed meeting. The totals are large.

The slowly moving merchant vessel faces the possibility of torpedoing a few hours after the voyage begins and continues to face it night and day for several weeks or until the voyage is completed. The continued apprehension of members of the crew constitutes of itself a stress of unusual magnitude. When the ship is attacked, the danger becomes real and the stress is greatly intensified. This change in most instances takes place without warning and represents a sudden, life-threatening situation. Some men are killed immediately by the force of the explosion. Others suffer severe physical injury. Those not suffering trauma at the moment are faced with having to man the crippled ship under exceptional circumstances for varying lengths of time. The ship may need to be abandoned in a few minutes after the attack is begun. In some instances there is not even enough time to lower the lifeboats. Fire makes the picture even more terrifying.

Those who survive these major experiennces to the extent of getting aboard a life raft or lifeboat are then called upon to suffer the physical effects of exposure to the elements with marked restrictions of food, water, and activity. That some should have a feeling of utter helplessness is not surprising. The matter of remaining afloat for hours, days, and even weeks under these circumstances constitutes a physical and mental strain which is quite likely to produce, even in the strongest individuals undergoing them, pathological changes in anatomy, physiology, and psychology. That great numbers of men have survived these ordeals is a tribute to their capacity to adjust to such unusual hardships; but the ordeal all too often is so severe and so prolonged that even experienced seamen with more than average stability break under the strain. Naturally, among the large number of inexperienced sailors are many who are susceptible to severe nervous breaks. Numerous psychiatric casualties have occurred. We want to prevent as many of these as possible, both in the veteran and in the new recruit, and to treat by the most effective means those who do succumb. I hope that the syndrome of so-called traumatic war neurosis will be discussed quite freely today with a view of arriving at the best possible means of prevention and of handling the individual cases with the maximum benefit in the shortest time possible. The longer a neurosis continues, the more unfavorable becomes the prognosis.

For a number of months the Public Health Service and the War

Shipping Administration have collaborated in a program designed to do all that is possible for these cases.

I should explain that the Public Health Service operates the medical service of the War Shipping Administration in a way comparable to that in which we give medical care to the Coast Guard. The scope and details will be presented by those who are doing the work. A considerable number of cases have been treated and the results are encouraging.

We must do our very best for these brave fighters of the supply battle, to keep them fit and to heal their wounds of body and mind. With this end in view, I welcome you to this conference. My colleague and I seek your aid in improving our services. Conclusions reached here also should have a direct bearing upon comparable problems in the other fighting forces.

Since all of us do not know each other, I am going to suggest that we have each of you in turn rise and give your name and your representation.

The first item on the program is a discussion of the program being carried out in connection with the Maritime Commission (War Shipping Administration), and United Seamen's Service, by Dr. Daniel Blain.

DR. DANIEL BLAIN: This group contains seven doctors who met with me several times last spring after the American Psychiatric Association Meeting in Boston, to discuss cases of merchant seamen sent to me by the British Vice Consul. Twice we were entertained at dinner by the Josiah Macy, Jr. Foundation, who are our hosts today. Some of us had been active in a seminar course of ten sessions on war neurosis earlier that year. As a result of these contacts, as well as of visiting hospitals in Halifax and the Norwegian Home for Seamen in Chester, Nova Scotia, and of a number of discussions with leaders of the War Shipping Administration and a large number of seamen themselves, I came to the planning of this program with a certain clear concept of the definition, treatment and prevention of traumatic war neuroses.

My first case was dramatic in its implications. A 27-year-old English boy presented three kinds of symptoms. He was mildly depressed; he had attacks of increasing tension when he felt he must cry out and yell when in a social group, at which he would leave and go to the men's room, weep for a few minutes and come back feeling all right; and attacks similar to nightmares before going to

sleep at night. In these attacks he would be ready to go to sleep when he would start thinking of various incidents—torpedoing in the Channel, a week of bombing in Harley Pool without sleep for a solid week, ships sinking around him in convoys, his 2nd mate who had gone crazy, planes diving, bombs dropping, home, his wife and the child he hadn't seen, etc.—the events of the last voyage with shortage of food, no refrigeration, bad feeling among the ship's company. Then memories followed each other faster and faster, racing around his head until he thought it would split. He would look around and objects appeared far away, his hand ten feet off, the house across the street ten blocks away. He would get up, walk about, smoke a cigarette and it would all pass off. Then he would go to sleep without further trouble. During this time he had palpitation, sweating, trembling waves of hot and cold over his body. There is not time for a detailed history, but he had an essentially normal past. There were some morbid facts in his life, but he had been doing well in business and had married a short time before the war opened.

He was trained for the sea. He joined up and had had two years and three months of a tough life—no real vacation, any number of bad actions, seen ships and men lost time after time, and didn't crack up through it all. Then a series of events occurred which appeared significant. The last trip began with delays—going aground in the harbor, removal of stores, more delay. Then long tropical experiences with no refrigeration and shortage of food, grumblings among crew and officers. Ulcer-like symptoms developed with increasing severity for three months, culminating in a collapse with terrific abdominal pain on deck the second night in New York. He was taken by ambulance to a hospital. There were no x-ray findings, no blood and the diagnosis was spasm. Discharged in two weeks as physically sound and told to rest up a few weeks for his nerves, he was never aware of being nervous or emotionally upset until just before leaving the hospital. Then he got despondent and unhappy and went to a hotel where his agents paid his room and board.

He soon spent a few dollars he had borrowed and could get no cash advance on his pay due in England. His consul could do nothing for him. He felt ill but could get no help. Although entertained at canteens and given free theatre tickets, he hadn't a nickel for subway rides or cigarettes. He came to me after three weeks, after telling the consul if nothing could be done for him, he

wanted to go back to sea and bloody well get knocked off. After a few minutes of talking, he suddenly came out with a terrific blast against his last skipper and for ten minutes poured out a mass of hostility that gave me the surprise of my life. Instead of all his other troubles, before and since his collapse, this one feeling that the skipper had grafted on the stores, was incompetent and had not properly kept his vessel fit, suggested itself to me as either the cause of his break or the last straw in a series of similar disappointments or causes of being let down. Then followed being sent out and told he was all right when he knew he was not fit to look after himself—government and old legal barriers prevented his having any money. A jeweler in New York took his watch for repairs and sold it, saying he thought the owner had gone back to sea. The boy was treated in my office and lost all symptoms, got back his zest for living and sailed away on a ship not bound for home. I had one letter shortly afterward.

His case showed several things. An emotionally healthy fellow had cracked up. He had gone through two years and three months of danger, strain, fatigue and all manner of experience before this occurred. A period of bad feelings with his skipper predominated over other feelings. He didn't crack until he was in harbor and was not aware of being nervous until he was told he was physically well and had been lying quietly in a hospital for a week. His symptoms increased as his environment added not to danger but to frustration. He was a relatively easy cure, but not with kindness alone. He had to have intellectual understanding of his symptoms and his feelings.

In order to show you one or two of the men we have actually been receiving, we have arranged for one or two patients to appear here. Dr. Hoch, will you bring the gentleman in?

Some of our men don't object to seeing doctors; in fact, they are rather flattered.

This is Mr. Lambert. Dr. Hoch, will you tell a little bit about Mr. Lambert?

DR. HOCH: Will you tell us what happened to you, Mr. Lambert?

MR. LAMBERT: Yes, sir. We had been under attack for two days in Northern Russia and on the 14th of September in the afternoon, they gave us a heavy attack. They attacked us with about thirty planes. They machine-gunned us and used heavy bombs. The fighting was very severe, so we must have got hit with a bomb.

I don't know exactly what hit us myself. I was knocked unconscious and I was unconscious for a half hour or more. I was told later that I got up and walked around the ship but I don't recall walking around at all. I was taken back to the sick bay of our own ship, but that was all blown up, too, and there was a British cruiser that came up alongside us and they removed those that were most seriously wounded. There were eight of us. So the next day we were headed back to Scotland, but I wasn't aware of that until the next day.

So when I did come to, my head was all swathed up in bandages, and my hands. We arrived back in Scotland and I spent two months in the Royal Navy Hospital in Aberdeen.

DR. HOCH: What complaints did you have in Aberdeen?

MR. LAMBERT: Severe pains in the head.

DR. HOCH: Anything else? Were you upset, nervous?

MR. LAMBERT: Yes.

DR. HOCH: Can you describe it, in what way you were upset or nervous?

MR. LAMBERT: Well, I couldn't sleep; as a matter of fact, I sleep very little yet.

DR. HOCH: Did you have dreams?

MR. LAMBERT: Yes, sir.

DR. HOCH: Nightmares?

MR. LAMBERT: Yes, sir.

DR. HOCH: Can you describe what kind of dreams you had?

MR. LAMBERT: I dreamt of convoys, dreamt of battles, of men screaming and shouting.

DR. HOCH: Are these dreams very clear?

MR. LAMBERT: Yes, sir.

DR. HOCH: Vivid?

MR. LAMBERT: Yes, sir.

DR. HOCH: Do you have the impression of being in action?

MR. LAMBERT: Yes, sir.

DR. HOCH: Were the dreams colored or black and white?

MR. LAMBERT: Colored.

DR. HOCH: You see the thing rather clearly as you saw it when it happened?

MR. LAMBERT: Yes, sir.

DR. HOCH: What other complaints did you have later on? Something happened to your speech, you told me.

MR. LAMBERT: Yes, sir. I stammered and stuttered for quite some time; as a matter of fact, I still do at times.

DR. HOCH: You still do at times?

MR. LAMBERT: Yes, sir.

DR. HOCH: Immediately after the accident, you couldn't speak at all?

MR. LAMBERT: That is right.

DR. HOCH: For how long?

MR. LAMBERT: Oh, quite some time. After getting back to Scotland, it kind of cleared up. Upon coming back, I couldn't talk very much at all.

DR. HOCH: I see. So your speech difficulty lasted about three weeks?

MR. LAMBERT: That is right, sir.

DR. HOCH: And then you started to stammer?

MR. LAMBERT. Yes.

DR. HOCH: Did you shake?

MR. LAMBERT: Yes, sir.

DR. HOCH: What complaint do you have now?

MR. LAMBERT: Well, I don't sleep very much and if I am up for any length of time, say, twelve hours or more without resting or sleeping, I begin to see double.

DR. HOCH: Yes, you see double with one eye, too; if you close one eye you see double with one eye; is that right?

MR. LAMBERT: Not as much as before.

DR. HOCH: And you are still shaking at times?

MR. LAMBERT: Yes, sir.

DR. HOCH: Were you nervous before all this happened to you? Did you consider yourself a nervous person?

MR. LAMBERT. No, sir.

DR. HOCH: You were quite calm?

MR. LAMBERT: Yes.

DR. HOCH: Did you fear that the ship would be attacked? Did you think of that?

MR. LAMBERT: Well, when we first started out, I did for the first few days, but that kind of wore off.

DR. HOCH: Were you apprehensive?

MR. LAMBERT: Not so much.

DR. HOCH: How long are you at sea, for a long time?

MR. LAMBERT: Fifteen years.

DR. BLAIN: Fifteen years. How old are you now?

MR. LAMBERT: Thirty-two, sir.

DR. BLAIN: You started off pretty young, didn't you?

MR. LAMBERT: Yes, sir.

DR. BLAIN: How did you happen to go to sea?

MR. LAMBERT: Well, I was young at the time and met a friend; he was with the U. S. Shipping Board. He gave me the details and I signed up.

DR. BLAIN: When did you get back to this country?

MR. LAMBERT: The twelfth day of December.

DR. BLAIN: What did you do when you first got back?

MR. LAMBERT: I reported to the Marine Hospital at Hudson and Jay Street and the doctor there examined me and I said I would like to go home and visit my family for a holiday. He said, "Very well," and I did, and I got back here in New York the eighth day of January.

DR. BLAIN: On the 8th day of January you got back to New York after the holidays?

MR. LAMBERT: Yes.

DR. BLAIN: When did you come out to Gladstone? Do you remember when you came to Gladstone?

MR. LAMBERT: Yes, sir; that was the 14th, sir.

DR. BLAIN: So two weeks ago, he came out to our place at Gladstone. Have you changed any since you got out there?

MR. LAMBERT: Yes, sir.

DR. BLAIN: What has happened to you since you got there?

MR. LAMBERT: I feel better all around, sir. I feel more rested.

DR. BLAIN: You feel better all around?

MR. LAMBERT: Yes, sir; and my nervous condition seems to be easing up.

DR. BLAIN: Were you sick any before this accident?

MR. LAMBERT: No, sir.

DR. BLAIN: What had you been doing on the ship?

MR. LAMBERT: Steward.

DR. BLAIN: You were in the steward division?

MR. LAMBERT: Yes, sir.

DR. BLAIN: What were you doing when the ship was hit?

MR. LAMBERT: Second cook, sir.

DR. BLAIN: Where were you on the ship?

MR. LAMBERT: I was near the officers' saloon. I had the first aid station.

DR. BLAIN: You were at the first aid station. Were you warned ahead of time? Did you know something was about to happen?

MR. LAMBERT: Yes, sir.

DR. BLAIN: And there was some warning in this case?

MR. LAMBERT: Yes, sir.

DR. BLAIN: What time of the day was it?

MR. LAMBERT: Around two-thirty or three o'clock in the afternoon.

DR. BLAIN: What were the other men like in your boat that you went off in?

MR. LAMBERT: Really, I don't know, sir.

DR. BLAIN: You didn't know anything about them. How were they the following day when you did know?

MR. LAMBERT: I was in the sick bay of this British warship. I couldn't move around.

DR. BLAIN: You can't tell us how the other men in the lifeboat were?

MR. LAMBERT: As a matter of fact, sir, we weren't in a lifeboat at all.

DR. BLAIN: You were picked right off the ship?

MR. LAMBERT: The cruiser came directly alongside us.

DR. BLAIN: So you didn't observe any of your buddies on the ship at all to see how they reacted to all this?

MR. LAMBERT: That is right.

DR. BLAIN: Thank you very much.

(The patient left the room.)

I haven't seen this man myself before. I would like to know what neurological condition he had. Perhaps we can find out from Dr. Hoch later. We will go on, because I think the other man we wanted to present isn't here.

Now, we get the impression from our cases that most of them give an essentially normal past. If you go into it, you can find something there, probably; but as a matter of fact that fellow had gotten along for fifteen years and he hadn't had anything serious happen to him.

(The next patient entered.)

DR. SHERMAN: Sit down, please. This is Mr. Andrews, gentlemen, who was in a torpedo episode on September 27th. There was no warning of attack. It occurred very early in the morning. They were attacked by what he calls a suicide squadron, consisting of one submarine and the activity of the submarine suggests that name. The convoy of eighty-two ships was on its way to Iceland carrying

general cargo. At the time of the torpedoing, the patient was amidships. He was injured by shell fire, receiving several shrapnel wounds of the leg.

The crew lowered two rafts to get away. The water was very cold. Fortunately, they were picked up within a period of about fifteen minutes by a corvette and taken directly to Halifax. The patient was in the Halifax Hospital for about two weeks, treated for shrapnel wounds and for nervousness, was again in the Boston Hospital and then came to New York where he was in the Marine Hospital for a while and then sent to us.

Regarding his nervousness, he states he had it really before the torpedoing that came at the last. For two trips prior to his last trip, he was bothered very much by the depth bombs constantly going off around him. The nervousness that he has now became quite severe when he came to New York. He finds it very hard to define. He says he is very easily upset, with tremor, restlessness and nervousness, particularly on trains. He noticed it this morning coming in from Oyster Bay. He has had the characteristic repetitive catastrophic dreams that many of these cases have, severe nightmares in which he sees the ship being torpedoed and tries to get off the ship. The dreams have stopped for several nights and are considerably better now, but he still has a good many of these general symptoms of diffuse anxiety, severe nervousness. He has a state of what he calls extreme worry and wants to quit everything and get away from things generally. That is his condition at the present time.

DR. BLAIN: We would like to have him tell us a little bit about it. Mr. Andrews, tell us a little bit about yourself, how you feel.

MR. ANDREWS: Well, I am not very much of a talker, you will have to excuse me on that point. I am very nervous, doctor, and I am very easily upset and especially when I get before people like this.

DR. BLAIN: I can understand that.

MR. ANDREWS: Just what do you want me to tell?

DR. BLAIN: Tell us how you felt when you first got nervous after this experience.

MR. ANDREWS: Well, when I came to New York, after I left the hospital, why I just wanted to get away from everything. In fact, when I get on a bus or subway or get around people I feel like I am being crowded and jammed into a corner or something, and I just want to push everything to one side. I get all upset very easily.

DR. BLAIN: Does it last long?

MR. ANDREWS: Until I can get by myself and not have anybody to bother me, and rest and take it easy.

DR. BLAIN: How long have you been to sea?

MR. ANDREWS: I have been going to sea for nine years.

DR. BLAIN: How old are you now?

MR. ANDREWS: Thirty-three.

DR. BLAIN: How were you *before* this accident? In good health?

MR. ANDREWS: Yes, sir; perfect health.

DR. BLAIN: Had you been nervous before?

MR. ANDREWS: No, sir.

DR. BLAIN: Did any of the other men have any bad results from the torpedoing?

MR. ANDREWS: Yes.

DR. BLAIN: And the bombing?

MR. ANDREWS: Yes.

DR. BLAIN: They did? Tell us a little bit about what you saw.

MR. ANDREWS: Well, one man that went over the side the same time I did, he had shrapnel wounds, too. He was very fortunate in being fat. He was a saloon messman. He had a piece of shrapnel in his stomach approximately the size of a dice box. The only thing that saved his life was being fat.

DR. BLAIN: How was that?

MR. ANDREWS: The doctors say—that is the way they explained it in the hospital—if it had been a person like myself, a rather thin person, it would have killed him.

DR. BLAIN: Did you notice nervousness among any other men?

MR. ANDREWS: Yes, sir; very nervous.

DR. BLAIN: What were they like?

MR. ANDREWS: They were upset and they never liked to talk about those things. They were very irritable, the same as myself at times. I think I am overcoming that irritability a little bit.

DR. BLAIN: This happened back several months ago, didn't it?

MR. ANDREWS: Yes, sir; the 27th day of September.

DR. BLAIN: What have you been doing since then?

MR. ANDREWS: I only made one trip.

DR. BLAIN: You made one?

MR. ANDREWS: Yes.

DR. BLAIN: Coastwise?

MR. ANDREWS: A 29-day trip.

DR. BLAIN: How did you get along there?

MR. ANDREWS: Not so good.

DR. BLAIN: Tell us how you were.

MR. ANDREWS: We didn't have much trouble. It broke out once or twice. I remember the first time very distinctly, because the time we got the general alarm it was at night, around nine-thirty or ten o'clock. I was in my bed and it was the first alarm heard since I was torpedoed, and I practically froze in my bed. I didn't want to get out.

DR. BLAIN: You couldn't move?

MR. ANDREWS: In other words, I was muscle-bound, you might say, for several seconds.

DR. BLAIN: How long between the time you got back and the time you shipped out, two or three weeks?

MR. ANDREWS: No, sir; it was longer than that, approximately a month.

DR. BLAIN: About a month later you shipped out yourself?

MR. ANDREWS: Yes.

DR. BLAIN: What did you do during that month?

MR. ANDREWS: During that month?

DR. BLAIN: Yes.

MR. ANDREWS: Well, I was in the hospital two weeks and I came down to New York and I went down to Philadelphia.

DR. BLAIN: Did you feel nervous during that month?

MR. ANDREWS: Yes, sir.

DR. BLAIN: You felt nervous the whole month, but you shipped back anyway?

MR. ANDREWS: Yes.

DR. BLAIN: Did anybody talk to you about war nerves at all?

MR. ANDREWS: No, sir.

DR. BLAIN: Nothing like that? Therefore, Dr. Sherman is the only one that has explained anything like that to you at all. Has he explained anything to you?

MR. ANDREWS: Yes.

DR. BLAIN: How long have you been out there at Oyster Bay?

MR. ANDREWS: Tomorrow will be two weeks.

DR. BLAIN: Did anything happen to you since you got out, have you gotten worse?

MR. ANDREWS: No, sir; I feel very good. Of course, now I am nervous today, naturally. I came over to the city yesterday. I had business in Bayonne, New Jersey, and the business I had took me all day and upset me quite a bit and I didn't get in until late yester-

day afternoon. However, I got a good night's sleep and felt rather good this morning when I got up.

DR. SHERMAN: Your sleep has been considerably better, hasn't it?

MR. ANDREWS: Yes, sir.

DR. BLAIN: Does anybody have any questions? This gentleman has had certain experiences and is able to express himelf pretty well, I think; if not, we are very much obliged to you for coming, and we hope to learn from these doctors here how to do even a better job on you.

DR. SHERMAN: This is Mr. George Weston, gentlemen.

DR. BLAIN: How do you do, George. Have a seat. We are very much obliged to you for coming.

DR. SHERMAN: Mr. Weston was in a torpedo episode in May, 1942. He was asleep at the time of the explosion which occurred at five o'clock in the morning. He jumped up and found his berth was all torn up. The doctor said later that he must have been blown out of bed in his sleep and then came to afterwards. He got to deck all right and made the last lifeboat off the ship. There was heavy shelling of the ship and he was excited and was not frightened at that time. His symptoms began immediately after the torpedo experience; about ten minutes after the submarine left the scene, he had severe headache and had body image disturbances and his head felt as large as a chair, as he describes it. He was unable to stand up. Later he had hand tremors. I suppose he still has them a little bit. There was a pendulum pain in the left side of the head followed by depression, quite severe; weakness of the wrists; the hands were stiff; paresthesia of the palms, which felt very thick. There was a severe delayed fright reaction which came a month after the disaster when he was in a parade in New York, sitting next to a man on a parade float. This man had been in the torpedoing with him, and this reaction was followed by diffuse anxiety.

The patient still has considerable anxiety. He has this tremor of the hands. He has the stiffness, the wrist weakness, and he has been worried considerably over a cisternal puncture which he had at one of the hospitals before coming to the rest home.

He has quite an unusual past. He was born in Antigua, British West Indies; went to sea very early in sloops, one-masters, and cargo vessels; was coal passer and deck man; married at 32, settled down in Boston, took night school courses and educated himself, is extremely well-read, a student of English and history. He did Negro

uplift work for many years, was cook for the New York Central Railway; organized a union and was discharged from the railway after that; went back to sea at the onset of the war, as he says, to make a contribution.

How are you feeling now? Do you feel you are any better since you got out of the hospital?

MR. WESTON: Not much better, with the exception I don't have the headaches so regularly.

DR. SHERMAN: The kind of headache you described before is not as bad as it was?

MR. WESTON: No, sir. Since I left the hospital, I had headache about . . . I left the hospital last Wednesday.

DR. SHERMAN: Will you describe that feeling you had shortly after the submarine left the scene when you were lying in the boat and your head felt so strange? Could you describe that, do you think? It was kind of swollen feeling, wasn't it?

MR. WESTON: Well, I wasn't expecting such a gathering here when I came in. I am somewhat off my equilibrium, so you will pardon me if I hesitate sometimes. I can't make any contact with the things I want to say. And since I came in here and saw so many people, I didn't know whether I was before the Fuehrer, whether I would go in and find the Fuehrer or Il Duce waiting for me, for having said what I said some months ago. So you will give me just a minute to gather my wits.

I explained to the doctor that there is a slight recollection regarding being thrown on the deck. It wasn't just that statement; the doctors told me when I said I woke up, that I must have been knocked out in my sleep and I came to. I thought I woke up. That is, I came to. That was what they told me in the hospital up in Maine.

I wish I had a friend of mine with me who did rescue me, the man who came back in the lifeboat for me, because he could tell you something that actually frightened me, doctor, a week after I left the hospital, just after I left you to come in and go to the neurologist. He came to my house and he told my wife that he didn't know how it was possible that I got out of that room, because when I stood at the rail of the ship and called at him, "Countryman, come back here and let me get in that boat," he said he thought I was a spirit, because he had been trying to get to that side of the ship, and where I slept was a mass of twisted steel and blaze coming up over

there, and he had to turn back and go around the other way to get to the lifeboat. And when I came out there, he thought that I was a spirit. So I looked at him and said, "Is that right?"

He said, "That is right. I couldn't believe you had gotten out of there."

He even said, "It is too bad"—they called me Doc. I don't know for what reason. He said, "It is too bad Doc slept in this room because he is really gone." And when he saw me appear on the rail of the ship and I hailed him, he thought that I was a ghost.

Now, when I woke up, what woke me was just the same as if you were sitting in an automobile and someone stepped on the running board and you were looking in an opposite direction, and just that slight movement caused you to turn. It was just that that woke me up. I woke up and I heard as I woke, "Lower away, lower away, lower away," and I wondered. I looked out the porthole, because there was a porthole right over my berth. I looked out and I didn't see anything extraordinary. So I reached up to turn the light on. I turned the switch and there was no light, so I turned the bulb, and there was no light. You see, the other cook who slept in the room with me—I was the chief cook and he was the second cook—when he was leaving the room (they never slept in the room at night; I always slept in my room) he would turn the switch or turn the bulb. So I turned the bulb. I turned the switch and there was no light. I turned the bulb; there was no light. I said, "Huh-huh, something has happened."

In the meantime, I had felt that things didn't feel right. Everything was all torn up, even my berth was ripped slightly and my head was somewhat down. But I was as conscious as I am now, and I felt under the berth where I had my things, shoes and stockings, so if anything would happen I would have them handy to get to them. Everything was scattered all around and I felt all around there. I found two shoes, and they were two left feet shoes. When I got in the boat, I found out. I didn't know what they were then. I put them on and I got my life preserver which, by the way, was a private life preserver I bought in Buenos Aires last January when I was there. I bought it there, and it kept me up 37 hours and kept sharks away from me. I have it home now.

I put that on and I found my way. I can't even tell you now how I found my way up to deck. And when I got up, I saw the chief mate trying to get things together. He had a bag and his

searchlight in his hand, and I said, "What is the matter? Have we been hit?"

Of course, he used the sailor's language to tell me that we were hit. He said, "You bet your boots we were hit." Of course, there was the sailor's language included therein.

DR. SHERMAN: Tell a little something of the shell fire.

MR. WESTON: After I got into the boat, they took me in the boat. I got in the boat. The submarine came to the surface and everybody was excited in the boat at the time. All of a sudden they got quiet and I heard whispering, "There is the submarine. There is the submarine." They were hollering previous to that, and they were saying, "There is the submarine," and everybody looked and kept quiet. Then the submarine shot out and shelled the ship over our heads. There were seven shells fired. I can remember very, very well. I counted them. And one of them missed, but six did trike the ship and in less than a second or two she went down and the submarine disappeared.

We pulled around for a few minutes and soon after that my head began to grow very, very large, and I couldn't sit up, and I commenced to throw up in the boat, and I had to lie down. I lay there for a long time. I was in the stern sheet of the boat and there was no one who could steer the boat while I was sitting there, so they gave me the oar and I was steering the boat this way, with the oar over my head, (demonstrating) for a while. Then another man took the oar and started steering and I shifted my position over to the other side of the stern and the submarine went away. At least, the submarine had gone then.

DR. BLAIN: What do you think you are going to do with yourself? Are you going back to sea again or back to Boston?

MR. WESTON: As soon as I am healed, I propose to go back to sea. Of course, my wife is objecting to my going back, but I still want to go back.

DR. BLAIN: We are very much obliged to you for coming. You told us a lot of interesting things.

MR. WESTON: I am sorry if I wasn't as clear as you expected me.

DR. BLAIN: You were very clear. You did very well. (The patient left the room.)

We feel that these people are coping first, with more or less of a normal reaction to a dangerous situation. The body-mind machine reacts in ways suitable to the animal level but often inappropriately

where defense instincts are not allowed complete sway. Physiological response often interferes with escape rather than helps it. The reaction may be overwhelming and give the appearance of a serious mental condition. Sufferers in this condition obviously need hospitalization, if possible.

It may be some time before this normal response to the immediate danger becomes connected with past experiences or joins with an earlier neurotic pattern.

Hence, normal people are vulnerable and react in a simple fashion. Those with neurotic background, we feel, may also react simply to the war experience and this reaction is not at first part of the life pattern.

Traumatic neuroses in war seem different from civilian neuroses because of the overwhelming danger in the war situation not found in times of peace. Although all the men I saw had been torpedoed some weeks before, they apparently had not yet settled down to any mode or place of living, hence could still be considered in "an early stage." The incipient neurosis encapsulated a surface phenomenon.

From this general idea developed the whole plan of treatment. Acute situations would be treated in the Marine Hospitals but we would advise withdrawing them as quickly as possible. From then on we determined to keep the condition entirely separate from other diseases, or the atmosphere of disease—in other words, from both general hospitals and mental hospitals. We would avoid all psychiatric terminology, call the condition "war nerves," a name with a non-affective connotation, speak of the problem as being strictly medical, call the psychiatrist the doctor, keep the nurses out of uniforms and substitute the designation of home for hospital. Our concept of pathology was possibly oversimplified in the idea, "He acts as if he were still in the midst of the *danger* situation." Our aim might also be simplified by, "Build him up, get rid of his symptoms, send him out as soon as possible with something definite he can use in the future."

This implied that he must go through with what he had—an educational process for both insight and knowledge useful in the future.

The habitual shrinking of body resources and the loss of self-confidence (ego) produced by the traumatic incident must be treated directly with every available tool. Hence food, vitamins, rest, massage and physiotherapy, sedation, exercise and suitable recreation on the one hand and personal attention, intelligent

interest and sentimental sympathy, well-founded reassurance, a doctor with good strong personality to lean on, a chance to discuss personal affairs privately and an accumulation of knowledge about one's self are the keystones of treatment.

These ideals are incorporated in our convalescent homes, of which we have five scattered over the country. If the men average three weeks, which they do so far,we can take care of 4000 a year, which I think is just what we need.

A compromise between small groups for personal attention and homelike atmosphere and larger numbers to lessen the cost per patient has set the optimum number in a rest home at 35 to 50.

The staffs have been kept small, the chief administration control of patients in the hands of a competent psychiatric head nurse, assisted by one or two nurses with general duty training. A secretary and business manager were chosen for personality and experience to help in the general program. For occupational therapy it was planned to get the men interested in jobs of repair, wood cutting, cleaning up and other chores usually found in a country place. It was first thought that nurses, business manager and superintendent could direct both work program and recreation and trained specialists would not be necessary.

It was warned that medical personnel would be impossible to get. However, these homes would be near large ports, where psychiatrists are usually found in greater numbers, and I knew of the tremendous interest civilian doctors had in war neuroses and I knew that every civilian was desperately anxious to get into war work. To conserve medical time, group talks to the men were started the first day on topics concerned with anatomy, physiology and emotional conditions, and often subjects requested by the men themselves were discussed. It was my habit at the first home to invite all the staff, including domestics and any visitors, to come. In this way the whole group became educated in a psychiatric point of view and this alone has contributed greatly to a harmonious atmosphere.

I estimated that one doctor on half-time could do the treatment if he spent three whole days each week. Hence I counted on getting my doctors from civilian psychiatrists, having them appointed as psychiatric consultants by the Public Health Service. I believed I could use women as well as men. So far my expectations have been justified and I have a competent staff at each home. I planned also to have a supervisor for each port who would oversee the work and organize a psychiatric clinic for those who had to stay in the city. As

you have been told, I have asked nearby medical schools to become associated with these places so as to get help and guidance for the staff of the school in order to guarantee good medical work; also to let them have access to good teaching material. My staff has given lectures in war neuroses to many student groups. We are ready to conduct courses using our material and experience for groups of doctors, psychologists, and social service workers, and plan to start the first course of training for volunteer nurses in war psychiatry.

A most important unit is our contact force of medical social workers. Each port has a representative of our department to handle admissions and follow-up work. Each admitting office is manned by a medical social worker and she brings to bear all the help from welfare and seamen's agencies and uses a corps of volunteers to accomplish a great deal for our men. Local social committees take care of providing entertainment.

Prevention is the ideal of any such program as ours. Generally speaking, the treatment that we give would be essentially what we would recommend if it could be applied in advance of the traumatic episode, and by this I mean not only the acute danger action, but a prolonged anticipation of such action. So far we have been unable to do more than theorize on the psychological first aid which should be given immediately when "war nerves" begin. We are at this moment preparing educational material for our seamen, to prepare them for the dangers ahead. The training in psychological first aid will be accomplished by lectures, special courses among the men on active duty, and printed material circulated on all ships and among all personnel of the Navies who will be likely to pick up survivors. We would appreciate any suggestions along this line.

Large recreation camps in order to boost morale and get the men ready to return to sea after long voyages in a less vulnerable condition are already part of the War Shipping Administration's accepted plan.

I believe the concept of a small, carefully picked staff with experience in mild emotional states and an interest in therapy rather than hospital adminstration, plus wide use of the desire of the public to have a share in the war, are the most important parts of our plan.

Needless to say, I have been given great freedom of action by my chiefs in the War Shipping Administration and every backing by the United States Public Health Service. We are here to broaden our concepts and get advice on improving our program from you gentle-

men who have so kindly accepted Dr. Parran's invitation.

CHAIRMAN PARRAN: Thank you, Dr. Blain!

As you note from the program we have listed three sections, the first on etiology and pathology; the second on treatment, and the third on prevention. We have asked for the first section Dr. Earl D. Bond of the University of Pennsylvania to take over and act as discussion leader.

Dr. Bond will come forward and take my place here and we will proceed with the first topic.

(Dr. Bond assumed the chair.)

ETIOLOGY AND PATHOLOGY

ETIOLOGY AND PATHOLOGY

CHAIRMAN BOND: The opening discussion of this section on etiology and pathology will be given by Dr. Paul Hoch, whom you have met already. Dr. Hoch!

DR. PAUL H. HOCH: Ladies and Gentlemen: The ideas on the etiology of the traumatic war neuroses have undergone considerable changes. Not many reports are available about the occurrence of this condition before the first World War. In the beginning of the last war, it was assumed that the conditions now called traumatic neuroses were caused by microstructural lesions in the nervous system. Oppenheim claimed that the "shell shock" produced a concussion which damaged the brain tissue physically, as in certain cases of head injury.

This theory was disproved later in the last war by the evidence that many patients developed "shell shock" without being near explosives and that many recovered when removed from the danger zone or when they came under the influence of suggestive treatment. Since then, more and more emotional elements were discovered in the pathology of the war neuroses. The organic etiology was abandoned and replaced by theories stressing the psychic origin. Different authors emphasized different aspects of the emotional causation. Most of them, however, assumed that a conflict existed between the sense of duty on the one hand, and the escape from danger on the other hand, which was solved unconsciously by a flight into illness. A primary gain of the traumatic neuroses was the desire to be removed from danger, in many cases progressing into a secondary stage of wishing to receive compensation or pension.

Freud believed that the self-protective mechanism breaks in these individuals and that the psyche is overwhelmed with stimulation with which the person is unable to cope. This inability produces anxiety states with diversified symptomatology.

Kardiner, on chronic case material, arrived at similar conclusions, believing that due to the trauma the person loses control of the situation, which causes lasting damage to the person's appraisal of his relationship to the outside world. He perceives the outside world to be hostile toward him. He tries to protect himself against this hostility. Rado again emphasizes that the emergency control breaks down in these persons and that unconsciously the trauma

fulfills the desire of the person to be removed from danger. The fear of war is later transformed into fear of life in general. He calls this reaction "traumatophobia."

All these ideas are certainly valid. Still, they do not explain the development of all traumatic neuroses. It is impossible at present to evolve one etiology, treatment, and prognosis for all known types of these disorders because the individual variations are very great, as anyone working in this field knows. We were struck, in our own material, by the inability to work out a common denominator for all instances.

The causative factor in the traumatic war neuroses is not very complicated and is common to all. This causative factor is the war with its deprivations, horrors, and discomforts, which provokes the mobilization of all the available mechanisms of self-defense. All this wears down the person physically and mentally. It is obvious that the causation is not based on one factor, but that there are many variables in the physical and mental field which have to be taken into consideration. And even the constellation when, where, and how the trauma happened, is of importance. All this makes it difficult to generalize or to compare one group of patients with another. In some of our cases it was apparent that the physical factor played a great role. Men, after being torpedoed, were in lifeboats, sometimes well over a month, lacking food and water and developing states of exhaustion. The traumatic neurosis which was not present in the beginning, developed after their resistance was lowered. In others, emotional factors played roles which were as capable, owing to the rising tension and apprehension, of producing exhaustion as physical effort. For instance, if the man was not well adjusted in the group in which he served, or if he was anxious about supposed laxity in safety measures, or if he was not treated squarely. In addition to the anxiety, a great deal of hostility was built up which contributed to the breakdown of the person.

We had men who, in the early phase of the neurosis, talked in a paranoid way about how the safety measures were inadequate, or that the skipper of the ship did not behave properly, or that they did not receive the proper attention when they arrived on shore. Dr. Blain has collected a number of such cases. We believe that this anxiety element is very important in the development of certain types of traumatic neuroses, and that the men should have what we call a "preventive assurance" that everything is done and will be done to assure maximum safety and security under given circumstances.

These factors already mentioned are especially at work in the type of traumatic neuroses which develop slowly. In many of our men, however, the traumatic neurosis did not develop after a period of physical or emotional exhaustion. It developed suddenly under the impact of an overwhelmingly terrifying experience. In this group of persons the trauma produces an emotional shock, as a gross bodily injury provokes a somatic shock. The emotional shock has, too, a tremendous impact on the "self-government" of the individual, which collapses totally or partially and is replaced by a state of anarchy that disorganizes the normal balance of excitation and inhibition in the organism. This disintegration of self-government manifests itself in three different ways.

1. Emotional storm. (Terror state, which leads to narrowing of consciousness, amnesia, confusion, or, in others, to stupor or excitement).
2. Mobility storm. (Trembling, shaking, or when inhibiting mechanisms have the upper hand leading to immobility and cataleptic states).
3. Vegetative storm. (Affecting all parts of the body but mostly evidenced by alteration in the sleep-function, in the function of the heart, or diarrhea, vomiting, anorexia and other vegetative symptoms).

This chaotic, catastrophic anxiety state is a primitive defense reaction which overshoots the mark. It is similarly observed in animals, as it was demonstrated by Pavlov, Cannon, Liddell and others. In this elementary phase of the traumatic war neurosis, not much conflict or gain can be detected. Complicated mental mechanisms ceased to function.

That such an anxiety state is not altogether purposeful is shown by some of our men who were so frightened that they had to be pulled out by others. Otherwise they would have died.

In some persons this terror state does not set in immediately after the accident. During the race with death they function automatically, but collapse after the exertion. A few of our cases behaved this way.

After a while this anxiety storm subsides and then the person begins to take stock. This leads into the second stage of anxiety. Many of his infantile fears become activated. He thinks about death. He perceives many strange sensations due to the disturbed integration of his body function. The main difficulty however, is that he does not have himself in hand. "I lost my grip," "I am

unable to control myself," as our men express themselves. Conflicts about duty and escape may enter in this phase of compensation. Slowly, this still flexible condition becomes fixed, and then all the mental pictures occur which are so well known in the chronic patient. We do not want to pay attention today to the chronic patients because we believe that our therapy should get in immediately, as in a surgical shock case. The first anxiety phase is a psychosomatic entity and has to be attacked with new methods of sedation or even anesthesia along with psychotherapy.

In our material the so often discussed amnesia factor appears to be unimportant. Many patients want to forget, and I think this tendency should be supported. Some of our men used alcohol fairly successfully to obtain this end. Only a few patients want to recall every detail of the accident. This effort to recollect becomes like a compulsion. The recall of events in such instances is helpful.

It was and is maintained by some investigators that the premorbid personality is the most important factor in the development of war neurosis. No doubt, in the traumatic neuroses of civilian life this holds true, and no doubt that even in a group of war cases previous personality changes could be tracked down. The vast majority of traumatic war cases will not show an abnormal hereditary background, and their personal histories will show good adjustments before the trauma (Bowman).

In our cases all kinds of persons developed similar reactions, with different physical constitutional make-up and personality traits. It was furthermore most surprising that if abnormal traits were found, they had no relationship to the recovery.

Among the Merchant Marine personnel are many abnormal personalities. Many of them went to sea to escape organized society or land. Many are alcoholics, having sexual and other maladjustments. Probably these morbid traits force these individuals back to sea, counterbalancing the desire to remain in a war neurosis. I am convinced that many of these individuals would have been screened out as unfit for military service because of a pre-morbid anamnesis. These same men show a strong tendency to recover after being exposed to very harrowing experiences. There are naturally other factors which put the seamen in a different category. Their services are voluntary, many are oldtimers in this profession, and what is most important, they are not entitled to a veteran's pension. But it shows that an abnormal personality does not necessarily lead to a breakdown or foster the tendency to remain sick.

Ladies and gentlemen, there are still great gaps in our knowlege. Why one person breaks down and the other not, is still a puzzle. Why one person recovers quickly, and others not, is again not well known. Why one person displays a hysterical form of reaction, the other an anxiety state, and why the third develops a gastric ulcer, is only scantily understood.

The susceptibility of individuals to emotional trauma is as varying as to infections. These differences we have to investigate. We believe that some of the gaps in our knowledge will be filled by today's discussions, others will be solved by future research.

CHAIRMAN BOND: Is there discussion on this subject of etiology?

DR. A. A. BRILL: I was very interested in what Dr. Hoch told us. As he said, he didn't tell us anything very new. Those ideas have been expressed by various authors, but all I wish to say is this: The first case of war neurosis that I saw during the last World War, that is, before we entered the war, was an English army officer who was sent to me. After I worked with him for about two months, I found out that he was nervous long before he went into the war. In fact, I thought that he came to me accidentally, but I found out later that for years he had my address. He kept it with him, and mind you, he was an Australian.

Well, then, since that time I concluded—and not just from this one case; I have been connected with the United States Facility 81 since the hospital started; I have analyzed some cases from there and a great many in private practice—those cases are ordinary cases which we are wont to call traumatic neurosis. As Dr. Hoch pointed out, their symptoms are different because we deal with different personalities.

"As many men as many minds." And different people express themselves differently, and the difference in the symptoms is due to so many things. I don't wish to indulge in any technical terms and say this kind of homosexual components, that kind of behavior. But each one has something to show which is different from the other. I would like to be able to leave here today and find something definite and special. I hope you will show it to me.

DR. EDWARD A. STRECKER: Dr. Bond, I am particularly interested in this phase of the discussion. Unquestionably the etiology and psychopathy of "combat fatigue" (which we have agreed to call

these conditions), is very deep and very profound. Of course, it must involve general etiological and psychopathological factors. In addition, highly personal factors must be implicated. However, within the limits of authenticity, the simpler the hypothesis, the more effective will be the therapeutics. It would seem to me, too, that the infomation we uncovered about so-called war neuroses or "shell shock" in World War I has a great deal that is transferrable to the present situation; that effective therapeutics will flow from the simple visualization of the emotional conflict: on one hand the danger situation, and also the thoughts and motivations grouped together and called Merchant Marine ideals. You have here a rather simple, workable hypothesis: a case of combat fatigue is the pathological compromise of the conflict between the dominant instinct of self-preservation and the danger and hazards incident to service in the Merchant Marine.

One thinks at once of the possibility of strengthening the second limb of the conflict. In the case of the soldier we think of adherence to tradition and discipline, desire to acquit one's self favorably, and many other things. It is not difficult, although far too little recognition is now being given to it, to visualize the Merchant Marine in this war effort as tremendously important, loyal, patriotic and exceedingly hazardous. In addition to the two units of the emotional conflict, there is usually a precipitating occurrence, whether it be concussion—I mean non-traumatic concussion—or exposure, deprivation, or something else.

Now, I do think that this hypothesis was fruitful in therapeutics of the war neurosis in World War I, and I see no reason why it should not be effective in the particular situations under consideration. We attached a great deal of importance to the amount of befogging of consciousness and it was our feeling that in a way the greater the disturbance of consciousness the better the outlook for the particular therapeutics of the case.

CHAIRMAN BOND: Dr. Kardiner's name was mentioned in the opening discussion. Dr. Kardiner!

DR. ABRAM KARDINER: I was very glad to hear Dr. Hoch's report, because it is a confirmation of an idea that I have tried to propound for years without much success. Dr. Hoch said that he found no consistency in the pre-traumatic personality. I wish to support him in this contention. You can find every variety of pre-

traumatic personality and, so far as I know, there are only a few criteria that we can use to indicate the kind of person that is certain to get a traumatic neurosis when exposed to the conditions of war. They are not very numerous. Stammerers are excellent candidates for traumatic neurosis; anybody with a history of stammering is bound to succumb sooner to shock than any others. People with a history of chronic autonomic disturbances do so likewise. But I can state with absolute assurance that anybody who has at any time in his life had a disposition to epileptiform reactions of any kind, be it in childhood or later, is found to succumb to a traumatic neurosis.

One of the reasons why we have great difficulty in solving the problem of predisposition is that we don't know precisely what to look for in the preceding history.

All systems of psychopathology that we have today tend to go in the direction of exploring the social relationships of the human being, and I can tell you, having studied this problem for many years, that it is a fruitless quest to derive the traumatic neurosis from disturbances in social relationships. This neurosis is a disorder of the executive system for action, and hence is a much more primitive reaction than the ordinary hysteria. Those whose neuroses depend upon defects in their social relationships, do not develop this particular kind of reaction. They develop the ordinary hysterias or compulsion neuroses or what not. It, therefore, behooves us to look in another direction, and I can only indicate the general direction, in which it may be found; I cannot tell you with any specificity.

I think that the predisposition to the traumatic neurosis is to be found in certain types of maldevelopment in the accommodation of the individual to the external world. I have this hunch largely because of some of the most severe cases of traumatic neuroses in which this part of their history seemed affected. What I mean by that is this: As children, these individuals with the traumatic neurosis, do not play like other children. They have a tendency to be overdestructive, which means, in effect, that mastery techniques were retarded. This was the only criticism that I was able to establish in the childhood of these people who developed traumatic neuroses later.

Now, I should like to take issue with Dr. Hoch on one point. He stated that the primary reaction of the traumatic neurosis is a defensive one. If so, it is a disorganized defense. The third symptom

is disorganization, and disorganization is followed by an attempt of the individual to withdraw not only from the danger situation but from everything else which he now identifies with the dangerous situation. The pathology depends upon the persistence of this inhibitory reaction and, therefore, he is unable to reestablish the control that formerly existed.

I should also like to take issue with Dr. Hoch on the subject of the amnesia. The amnesia is only one minor symptom of the whole thing, and in a large number of cases it acts as a bell-wether of the progress of the whole case. There are some cases wherein you can recover amnesias and nothing will happen, and in other instances the recovery of the amnesia is an absolute essential for the recovery of the patient; simply because he indicates by the ability to recover the amnesia that he no longer needs this protective device of forgetting or withdrawing from the environment. So it is an indicator of recovery rather than a means of effecting it.

Dr. Howard Rome: I have had the opportunity of confirming Dr. Kardiner's observations in a somewhat different group. I have seen the Marines, who have been stationed on islands in the South-west Pacific, the isolation of which is obvious. Those who had traumatic neuroses acquired in combat were subjected to bombing during the day and to field maneuvers at night and were consequently unable to escape a chronic frustration and its resulting tension.

Dr. Lawrence S. Kubie: My impression is that a delayed reaction to the torpedoing is not basically different from an immediate disturbance; because a careful investigation shows that the upset was brewing, but that the individual had been able to suppress the symptoms and to maintain certain compensatory functions during the interval. Therefore, I am going to take it as my working premise that the immediate and delayed disturbances are identical. Naturally, superimposed upon these primary reactions, whether immediate or delayed, a slow accretion of complex secondary symptomatology can go on for weeks, months, or even years. Into this secondary structure flow confluent streams from every aspect of the individual's life. This, however, is no longer a primary reaction to the experience alone. It is a latent civilian neurosis, ignited by the primary neurotic reaction to the trauma.

The primary reaction, itself, can be divided into two essential

components. One evolves directly out of the panic of the experience. The other follows soon after in the form of a haunting depression. This depression is described by almost everyone who has been subjected to prolonged experience of this kind. It does not occur where the experience is over in a few hours, but only where it is long drawn out. The men in "The Raft," for instance, describe a cloud of deep and poignant gloom which would settle over them periodically for months after their rescue.

I emphasize this haunting depression, because it is usually overlooked and because it is of special significance in the neurosis among seamen. The seamen of the Merchant Marine are in certain respects a group apart. Although one must agree with Dr. Kardiner that the multiplicity of the human factors underlying the traumatic neuroses must be kept in mind, yet there is something common to this group of men which emphasizes the depressive component in their traumatic neuroses. In the first place, most of these men have gone to sea very early in life partly to escape ordinary home ties. Except for the Negroes and the Latin Americans, relatively few of them are married. Furthermore, they form limited human relationships with their fellow-seamen. During a trip their bonds to one another are often friendly and warm; but these ties are usually severed at the end of each trip. Only exceptionally do individuals pair up as buddies and ship out together. Thus, their relationships to one another are shadowy and transitory. The same forces which early in life drove them away from home make sustained friendships impossible later. As a result, they become for one another the repositories of all kinds of unconscious feelings drawn from childhood. They are objects of strong but temporary attachments, of close identifications, and of sharp but masked hostilities. That is precisely why their bonds are transitory. And that is also why when shipmates are injured or drowned before their eyes it is inevitable that they go into depressions in which they are haunted by feelings of guilt, as though their survival was at the expense of those who were lost. Indeed, this is the constant content of the depressions which arise after this type of experience. It is intensified by the traditional attitude of "every man for himself," which is accepted when the order comes to abandon ship. So much for the element of depression.

The element of panic in the primary upset is the most general reaction to all traumatic experience. It arises when the friendly sea suddenly becomes the seaman's deadly foe. It is not merely

because there is no avenue of escape, but also because every familiar object around him has become his enemy. Yet the seaman is a seaman because he feels safer at sea than on shore: more relaxed, less tense, less restless. So true is this that in some cases men who have been through repeated harrowing experiences have said in perplexity, "I don't know why it is, but when I am on land, I get the jitters. When I get on a boat, as soon as the engines start, I feel all right, even though I know that I am going back to the same danger." So great is the emotional power of the fantastic significance of the ship and the sea that it blankets the normal reaction to the anticipation of real danger.

But at the moment when the ship is torpedoed, it is as though their haven of security had suddenly turned on them. At that moment the man becomes paralyzed, because he cannot move in any direction without facing terror. This is characteristic of every situation in which anxiety becomes a paralyzing force instead of mobilizing and freeing effective action. Subsequently this pent up terror state gives rise to nightmares in which the sailor relives the terrifying experience in an effort to find a happier ending. His mounting terror wakens him each time; and in time this repeated experience leads directly into the evolution of the full fledged traumatic neurosis.

CHAIRMAN BOND: Dr. Kubie has opened up an interesting side to this. Is there further discussion?

DR. SANDOR RADO: I fully agree with Dr. Strecker that the conflict between military duty and self-preservation is the psychological background of the war neuroses. However, this theory is yet too vague to guide us in prevention and treatment. We may make it more specific and thereby more useful if we realize that the organism is equipped with an integrative system, "emergency control," which regulates its behavior when it is exposed to injury. The classical investigations of Walter B. Cannon have shed much light on the physiological workings of this control. Psychologically, it operates with a set of regulatory devices brought into play by the threat of injury. On the lowest level, this device is pain; on the affect level, fear and rage; and on the highest level, anticipatory thought. These devices in turn evoke the behavior patterns of riddance, flight, combat, and the call for help, designed to end or forestall the emergency. If emergency control is permitted to function as usual,

the individual has no chance in combat.

Therefore, to become combat-proof, the soldier must learn how to shut off completely this control and respond to danger no longer as a sensitive man, but as a technician of war. Lack or failure of this adaptation exposes the emergency system to excessive activity and throws it out of order. In my opinion, this state of dys-control is the first step in the development of all war neuroses. Subsequently, the disturbance spreads to other systems or deranges the entire personality.

From this point of view the war cases may be classified as incipient, acute, and chronic dys-control, reactive depression and schizophrenic episode.

Incipient dys-control was studied by Armstrong in flyers and termed "aero-neurosis." Acute dys-control may be subdivided into discharging, symbolic, inbound, and reactivating types. The first includes anxiety and rage attacks and states, the second the hysterical conditions, the third the psychosomatic disorders, and the fourth the revivals of the morbid pre-war personality patterns. Chronic dys-control is the traumatic neuroses proper which I suggested should be designated "traumatophobia." It is characterized by the dramatization of a "trauma," the dread of its recurrence, *i.e.*, dread of combat and later of life, inhibition of repair, craving for compensation, etc. The reactive depressions and schizophrenic episodes are outside our present interest.

A few words about the treatment of acute dys-control. In the last war "hypno-catharsis" or "narco-analysis" was employed to revive repressed war memories and discharge the "strangulated" affects. The results were discouraging. The soldiers relapsed as soon as they reached the front. Obviously, emotional purge cannot give more than temporary relief. In my opinion, the first task of treatment is to de-sensitize the soldier to his horrifying war memories by stripping these memories of their power to perturb him over and again, and instead turn them into a source of repeated pride and satisfaction. During this procedure the over-active affect systems of emergency control must be calmed down by appropriate medication. When the symptoms, including the terror dreams, disappear and the soldier's initiative is restored, he must be retrained and taught the proper psychological technique of behavior in combat.

If treated immediately, the incipient and acute cases may be returned to combat duty. But once the condition becomes chronic the man is lost for military service and unless readjusted soon to a

civilian occupation he may become incurable.

For a long time the merchant seamen were the forgotten heroes of this war. It is gratifying to see that under the able leadership of Dr. Blain such a splendid organization has been dedicated to their welfare.

CHAIRMAN BOND: Dr. Deutsch!

DR. FELIX DEUTSCH: I want only to stress a few points of practical importance. We saw here three cases presented, one the amnesia type, and as we looked at that case carefully, we could see his pre-traumatic personality. He talked with closed eyes today, in a detached way, showing his tendency to amnesia.

The second I would call the worrying type, with anxiety, and the third was the type who told all that he experienced to bring back to reality, to impress us with details which he had observed in this great danger, in which his whole interest could only be centered to be safe. When I looked at this case, I recalled the experience which we had after the Cocoanut Grove disaster. There we had a real example of a trauma which was inflicted on individuals by their pride. We saw the same kinds of reaction which were described here. One reacted with an amnesia and couldn't remember anything that had happened during the fire. The other brought a complete, detailed description, how he saw the fire coming and how he tried to save his neighbor and what the neighbor did, and when we checked up these stories, we found they were mostly invented. They were the reaction of the individual who by all his anxiety in a reality experience showed today his defense mechanism in protecting himself against anxiety. Others do this by amnesia and still others by becoming the worrying type.

We have a practical purpose here, and it is how to treat these patients. Our experience in Boston in civilian war neurosis started months ago, showed us as soon as we lose track of the goal which we wanted to reach, we are lost. This goal can only be to bring back the patient to the condition in which he was before he had this traumatic experience. If we go further, we find we are lost, because we treat then a heroic neurosis. The technic has to be to know the pre-traumatic personality, to go then only in that direction; that is, to treat him, this part of his personality, an elective part of the personality, which was shaken in this moment or in the trauma, and then to be satisfied that we brought him back in this condition in which he was. We would be unable to continue our treatment

to the end because of lack of psychiatrists. Because of lack of a big staff, we are now burdened with cases in which we cannot finish the treatment because there are infantile neuroses which you can stir up in any treatment, and they have been stirred up and we cannot leave the patient alone any more. Therefore, the goal has to be to treat this part of the personality which was shaken through the trauma and then to be satisfied.

CHAIRMAN BOND: Is there further discussion?

Dr. Blain has suggested that possibly there would be some case in point from one of the Marine Hospitals.

Dr. Vestermark!

DR. S. D. VESTERMARK: Mr. Chairman, in complement to these cases presented by Dr. Blain, I would like to recite the experience of a 17-year-old leading gunner in the Navy. This individual came into the hospital, was sent to us after having been picked up by the immigration authorities. He was sent in because he couldn't be aroused. He was sleeping. I was called to see him in consultation. He was still sleeping. So we let him sleep without disturbing him, and when he got up, he told us his story. It was simply one of fatigue, and he related some most unusual experiences.

He had been going to sea for two years. Off the coast of Iceland, the ship was bombed and he was in the water for two weeks, came through that experience without any handicaps or any difficulties. He suffered no physical disability and no mental trauma whatsoever. Six months later, while in the Mediterranean, he went through another bombing experience and spent about three weeks off the coast of North Africa near Tobruk. He then reshipped, came to this country, accumulated all of his savings, jumped his ship and spent about £500 in the course of a month's time enjoying himself.

Here was an individual who had gone through some of the most terrifying experiences. He showed us in his pre-traumatic or his pre-morbid personality many psychopathic traits and many psychopathic tendencies. In addition to that, he had other neuropathic traits, sleep walking, bed wetting, nail biting, temper tantrums. He would be, in all likelihood, that type of a personality that you would expect would crack or shatter or break under the impact of these terrifying experiences.

It is my feeling that in dealing with these people that there is, as has been stated, a very definite type of underlying personality

structure. I think that is related to the amount of time that we spend with these people; if we have adequate time and opportunity, we can find in most of these people some underlying pre-existing personality distortion or maladaptation that would lead us to believe that eventually this individual would be a potential candidate for some type of a breakdown under various stresses and strains.

We feel that these people cannot be treated in the hospital. As Dr. Blain has pointed out, they become dependent, attached. The depth of their neurotic disturbance becomes accentuated or exaggerated, and it has been our experience that the quicker they can be gotten out of the hospital, perhaps some of them sent to a convalescent home, as Dr. Blain has pointed out, they will recover much more quickly.

As Dr. Rado has pointed out, we make no attempt to go back any farther than treating that part of the personality which has been disrupted or traumatized by the experience. Any attempt to probe or search for or seek any deeper into underlying unconscious motives or mechanisms will only serve to prolong, exaggerate and make worse the condition for which the individual has come to the hospital. So we devote ourselves—the reason is simply a matter of expediency—to getting the individual out because of the factor of time; secondly, because we do recognize that if we attempt to treat the underlying personality disturbance, we then induce a chronicity which makes for further difficulty.

CHAIRMAN BOND: Is there a chance that we might hear from the Surgeon General of Norway, Dr. Karl Evang?

DR. KARL EVANG: Mr. Chairman, speaking generally here of the etiology, I think there are a few fundamental points which ought to be stressed as far as the sailors on the merchant fleets are concerned. I am not a psychiatrist but I have seen a host of those cases. One thing, which is quite obvious, is that the sailors of the merchant fleet, even if they are fighting in the front line, are not protected by a military organization; and they are not strengthened by the fact that they are cooperating and fighting together with the *same persons* for a long time.

The other thing which I should like to stress is the fundamental difference between the crew of a merchant ship and the crew of, for example, a destroyer or a cruiser, or the members of a military

force on land or in the air. The sailors have no means of fighting back.

In the Norwegian Merchant Fleet, for example, it happened that we had to wait very long until we had protection for our ships, and our feeling was that even for the men who were not gunners themselves the very fact that they had a gun on board was an improvement. It happened again and again, when you spoke to people being rescued from a raft or a lifeboat, members of a crew having been through indescribable hardships, when you asked them what they would do afterwards, they would say: "We are going back to sea, but this time couldn't we first go through a gunner's school so we would be able to fight back?"

I think those two fundamental differences should also give us some guidance as to the prevention of war fatigue.

Another thing I should like to stress from my own experience in Norway during the warfare is, again, something obvious. It is the surprising, the unexpected, the thing for which you have not prepared, which is bad. I happened to see much of the German bombing of civilians and defenseless towns of Norway, where the German planes could do what they liked, because there was no protection at all, no fighters, no anti-aircraft guns. I really saw very bad effects on the population in one single spot and that was in the bombing of the second day of the war in a small place called Elverum. I saw much worse bombing later, with more German planes and more terrible destruction, but the fact that the people of Norway had heard about these things and knew that they might happen, was a protection to them, not, as the Germans thought when they showed the terror film from Poland, that it would break down their resistance.

I would like to close by mentioning the case, from Norway, of quite another type of mental disturbance as the result of war. It was a highly educated man, a civil servant, a very fine man at his best age, in good strength, in the north of the country, which was isolated from the south. He developed in one month a picture which resembled megalomania on a syphilitic basis, in spite of the fact that there was no syphilis at all. He had the feeling that the war threw upon him as an individual all the responsibilities, the military responsibilities and the civilian administration, everything. In a short while, he tried to organize the whole country. He died from his disease.

Well, asked to speak here, I would like to thank you for the in-

vitation and I would like to address my thanks on behalf of the Norwegian sailors first and foremost to Surgeon General Parran. I agree with those people who think that the sailors in this war are not only the forgotten men but the forgotten fighters. There are many things now indicating that we are through with that period, that we all see what we have done wrong by not understanding it before. Thank you!

CHAIRMAN BOND: We are nearing the end of this part of the discussion. Is there anything that General Grant, of the Air Corps, would add?

DR. DAVID N. W. GRANT: Gentlemen, I am not a psychiatrist, but from the standpoint of the flyer, of course, I have been interested in this matter of neurosis and stress, or whatever term you desire, for many years. We, of course, have a selection for our people, not a very scientific classification, but I would like to classify our youth into five types. We feel that every man has a barrier as to what he can take, according to the work that he is to perform. Our selection system is based on that fact.

We, for instance, (and I admit this is a very unscientific classification) have the emotionally unfit individual, who is not a coward but he just hasn't the nervous stability to take the stress and strain required in the flying game. He will last two or three missions and then he breaks and he is certainly not qualified for combat flying again.

Then we have the constitutional type that we consider as a coward. He will take one mission or three missions, five missions. He never reaches the target and he is of no further use to us.

We have the fair-weather type who always finds fault with various things. The ship is wrong, he doesn't want to fly this ship, he wants to fly the other ship. He wants to be in pursuit, or if he is in pursuit, he wants to be in observation, and vice versa.

Now those three types we try to throw out in our selection.

We have two other types which we call the below average type and the average or better type. The below average type is a man who will "take" just a little less than the average individual, and if we get him and rest him, why he will come back and take it again.

The average or better type is the man who is the average individual and he is the man with whom we have trouble, because he will never come to us and tell us when he is trouble.

Now, we have set up our main problem as selection and maintenance. We also have a problem of classification. We don't take any of these individuals and just put them in "hit and miss" classifications of whether they are going into bombardment or pursuit. We try to classify them, whether they are fit for that particular type of work. Or if they go to altitude, they are also classified for altitude. We can't take every man and shove him up above 30,000 feet.

We also classify—though not to a very large extent as yet on account of the lack of instruments—on night vision, particularly the night fighters. We have followed the principle that we can take the below average or the average man and set a goal for him and pull him out at the end of that goal and rest him for a short period of time and then put him back. He will reach that goal again, and we can repeat it over and over again, and it works.

I have just returned from Africa within the month, and I find men over there with fatigue conditions, but we can't pull them out and rest them in between their combat hours. We have got men, entire crews, with 250 combat hours. One crew had 311 hours of combat. Now, we have set our goal at 120 hours of combat. Honestly, those crews are very much in need of relief on the front. I object very much to the use of the term "psychoneurosis" in connection with these people.

I think with our people we have a tendency to confuse the war neuroses. This is not the case—if we can get these people back and give them proper treatment, we can salvage the majority and put them back.

I might say this, that the higher the imagination,—which you all know,—the quicker they go out on you. We have much more trouble with our navigators than we have with the pilots or with our gunners. The navigator will go first with us and recover faster. The gunner has very little imagination or he certainly wouldn't be back there in the rear. He will take a hell of a lot. When he goes, he is gone.

We have to be very careful in pulling those people out. I think we are accomplishing a great deal. We are certainly making every effort. We have had very little difficulty in the actual loss of pilots. We have had a lot of strain and a lot of stress, but we are losing very few men for future use.

I feel this very strongly—you have probably seen it in the papers just recently—because of the fact that we have now in every one of our hospitals a convalescent reconstruction program that covers every

man in the hospital, in which, from the very minute he comes in and is able to do anything at all, he is placed on the system of exercise, of education, and other reconstructive ideas. For instance, at Jefferson Barracks, a man comes in for an appendectomy. The next day he starts his program and they make him exercise his hands. The next day he gets instruction in the ward about "booby traps" or what have you,—something to keep his interest up. We consider, you might say, this mental treatment to be just as important as the surgical or medical treatment. It is in effect in all of our hospitals today. Some of our hospitals have been slow in starting, but others have done a grand job with it.

CHAIRMAN BOND: We are coming to the end of this third of the discussion just on time. I want to thank the distinguished members of the conference who participated and I now turn the session back to the presiding officer.

(Surgeon General Parran resumed the chair.)

TREATMENT

TREATMENT

CHAIRMAN PARRAN: Thank you very much, Dr. Bond!

These sections merge more or less one with the other. I realize that in a group such as this it it difficult to get the discussion down to the informal basis we should like to have, but I hope we shall continue to move in that direction.

There are a number of guests from our allied nations whom we would have wished to call on this first section, but we hope they and everyone here will have something to say on one or another of these topics before the day is over. We shall proceed next to discuss the problem of treatment. Dr. Arthur Ruggles, President of the American Psychiatric Association, will please take the chair.

(Dr. Ruggles assumed the chair.)

CHAIRMAN RUGGLES: I think in the matter of treatment, we should remember the words of Dr. Parran, that the maximum benefit in the shortest time should be our aim in this discussion. There are many refinements of treatment that we would like to consider as research problems, but we are all interested in the benefit to the man and the benefit to the service, and that means the greatest benefit in the shortest time.

Dr. Blain has brought up a number of the things that they do in the matter of treatment, and I hope we can get time to dwell at reasonable length on some of those particular things. He spoke of occupational therapy. There are certain connotations in occupational therapy applying to this particular group that we haven't thought through, and also the question of the problem of the home against the hospital, the nurse in uniform and out. So that I think we should make this discussion very practical and keep in mind the experiences of those who have dealt with these particular individuals.

The first speaker on this subject, to open the discussion, is Dr. Stephen Sherman. Dr. Sherman!

DR. STEPHEN SHERMAN: Thank you, Dr. Ruggles!

The treatment of the merchant seamen's war neurosis, idealistically speaking, should begin with the period immediately following the traumatic episode itself. Everything that happens to the seaman from the time that he enters the lifeboat bearing him away from the scene of the disaster may be said to be therapeutic or non-therapeutic to a high degree; the attitude of the crew as a group toward what they have been through, toward such powerful etiologic agents as panic, loss of shipmates, sights of unusual horror, or screams of dying companions, and so on; more particularly the attitude of superior officers toward the total war experience, which attitude weighs heavily in the mind of the average seaman; in other words, all those factors, subtle and overt, which have to do with the presence or absence of war morale, both individual and group. By and large, the tone of the merchant seaman's morale suffers from a dearth of group feeling. That extra something which the army private has by way of his regular camp training and his identification with the Army, country, and the national cause, the seaman has only when he has been able to supply it from resources within himself. A program of psychological first aid, to function directly from the time that the seaman becomes a survivor, could well be instituted for the Merchant Marine.

In this it would be the duty of one member of the surviving crew to assume leadership and to regard himself as responsible for group morale until safety was reached. Muscular activity, as a means of releasing tension from pent up feeling, could well be encouraged. The men should be stirred to arouse and vent their anger over what they have been through, so that the foundation of repressed complexes through frustration could not be laid. It is possible that adequate psychological handling of the period directly following the catastrophe would fragment and disperse many of these traumatic war neuroses in the formative stage. But our experience in this realm is nil; we can only speculate and plan for the future and must pass on to a consideration of what we are actually doing for these cases.

The aim of the therapeutic scheme to meet the needs of these war neuroses cases is to catch the psychically disturbed seaman as soon as possible after he reaches shore. Where it can be arranged, a medical officer, together with a social worker, meets the incoming ship bearing a load of survivors. Signs of nervousness and mental distress are noted, and the potenially ill seaman is informed of the existence of the available rest homes, or is referred to one of the seamen's

clubs where he may further contact a physician if he so wishes. The effort is made to establish in the mind of the homecoming seaman that he is not alone, that he will receive the same regard and care as a member of the fighting forces, that his country is aware of his services and is eager to provide for his needs whether in sickness or in health. This note has been made to permeate the rest homes treating the cases of actual neurosis. Cases for treatment at the rest homes are selected with care. Very sick cases, those with active psychosis or developing states of acute mental disease, are referred to the psychopathic wards of the marine hospitals in each port. The rest homes are reserved primarily for the treatment of the fresh cases of traumatic war neurosis. It is believed that when a case is caught early there is excellent chance of forestalling the development of a severe chronic neurosis, and that the earlier the therapeutic interference the better. To quote a division psychiatrist of the A.E.F. in 1918, the treatment of acute neurosis is almost as urgent as that of acute abdomen.

The seaman comes to the convalescent home with various misgivings. He fears very often a sumptuous environment with overtones of patronage before which he will feel compelled to adopt a cringing attitude. He finds instead something extremely simple, though nonetheless carefully worked out; a social atmosphere of comfort with a slightly Spartan touch, informal to a fault, hospitable but not unduly solicitous, guided by certain rules and regulations which are not all-embracing, and presided over by a cheerful, understanding head nurse who steers a delicate course between firmness and sympathy.

In the psychiatric base hospitals in France in 1918, it was observed that in certain wards the men felt they could not hold on to a tic or a tremor because it was against the grain of the ward's morale. A similar kind of morale is labored after in our rest homes. The men are given to feel through the house atmosphere that it is the customary thing for improvement to take place. All the adjuncts to this fundamental note fall in line; the way in which the affairs of the home are conducted generally, the recreation activities, the entertainments, the special pursuits provided for individual cases. An important ingredient in the whole supportive regime is the friendly interest of neighbors in the community who provide dances, sports events, and dinners for the men. These neighbors are chosen carefully with an eye to their tact and acumen in the handling of personal relationships.

With the morale of the total supportive regime as a base, treatment from there out is less complicated. No mention is made at any point of psychiatry, nor is psychiatric verbiage permitted among the staff. The seaman is never allowed to feel that he has become the victim of a mental illness, but is constantly led to feel that his symptoms are not signs of sickness but of normal fear. The approach to his war experience and his anxiety problem is this: that of course he has been afraid, that there would have been something wrong with him if he had not been afraid, that it is merely a question of whether he is to be the boss of his fear or vice versa. The simple term "war nerves" is used to cover the varied symptomatology presented, which, as in the case of the indeterminate label "N.C.A." employed in the Army in the last war, leaves little for the patient to cling to as a stigma. The house staff as a group is oriented to encourage in the men the development of aggressive spirit, to inculcate the feeling that by pulling one's self up by one's own bootstraps one can do a great deal. At all times the supportive regime is left lax enough to make room in each case for individual initiatives. The psychiatrist is not designated as such but is known simply as a doctor; he starts out as a physician and only winds up as a psychiatrist.

To come to treatment of individual cases, what do we do? Going on the theoretic assumption that the acute traumatic war neurosis is a surface phenomenon which has not yet struck deep into psychic strata, our aim has been to quiet the underlying neurosis if it is there, but to treat the acute neurosis. It is astonishing to find how a case responds to the immediate impact of the total supportive regime.

The quiet and comfort of the spacious country scene, isolated from civilian pursuits; clean linen; rest and good food; regular hot drinks and eggnoggs at special hours—all have their combined tonic and sedative effect. Many of the men have come from several weeks of loafing around the dock district; many have accumulated the dregs of an alcoholic debauch. In the majority these experiences have not helped the neurosis. The outstanding symptoms—severe insomnia, diffuse anxiety, tremors and startle reactions, autonomic disturbances of all sorts—show an almost immediate lessening of intensity. The treatment of the acute anxiety state is a problem in itself which time does not allow of proper consideration here. Suffice it to say that in it medical and psychiatric treatment are combined, and that goal is to effect a breaking through into a new phase in which the patient is therapeutically labile. Certain cases are candidates for special attention in this regard.

Mention has already been made of the seaman's particular character problem, his adjustment to the group and to group feeling. To use Dr. Glover's construct from the Bible, that in this weakness there may be a lot of strength, it was presumed that the seaman would respond to an approach along the lines of this very deficiency in his make-up; namely, that he would accept hospitably some form of group therapy as opposed to individual. This supposition was correct.

During the opening weeks at the Oyster Bay home, Dr. Blain undertook the task of giving the men group talks on topics germane to their condition; war nerves, the importance of rest, sleep, work and play; the use and abuse of alcohol; the role of feelings in nervousness, and so on. These talks were cordially received and have been continued by the incumbent physician. It was found that the men could assimilate in a group lecture certain ideas which were painful and unacceptable in private. The main thread running through all of the talks has been the invigoration of self-confidence through a working knowledge of the body systems, so that one may be aware of the physiologic resources at hand in time of danger, the systemic defenses upon which the torpedoed seaman may count to bolster his morale. Discussion of psychic disturbances was kept simple and elementary, the principal effort being toward showing the importance of normal fear as a defense and safety measure, giving the seaman to feel that many of his symptoms derive rather from an excess of certain good qualities than any imagined defect of personality. This was the practice with the armed forces in 1918 and it was highly successful.

To come to individual therapy, each seaman receives upon entry into the home a preliminary interview with the physician which serves to orient the latter to the case and establishes the basis for further work. It may not be advisable to elicit the full history of the traumatic episode at the first meeting. Procedure following the first contact with the patient varies widely. In all individual therapy with these cases, the physician is schooled not to ask but to listen. The patient himself is allowed to determine the depth of the treatment. There has been a strict avoidance of the tendency to go in and plow up the wounded psyche. Patients have shown varying degrees of the need for emotional catharsis. In many it has been deemed wise to let the protective amnesia alone; it serves a healing purpose. When the patient himself unlocks the amnesia and lays bare the content of the traumatic episode, effort is directed toward

establishing in the patient's mind, in accordance with Kardiner's formulation, a connection between symptom, trauma, and present tendencies to withdraw from the world at large. Here are a few thumbnail sketches showing the diversity of response to therapeutic approach:

A tall, gangly Texas broncho-buster of 25, only a few years at sea, went through three equally severe torpedo disasters in five months. He noticed no symptoms until after the third experience, when he realized that he was nervous, shaky, irritable, and considerably speeded up. When he came to the home, he presented a mild manic picture, gave out that $200 had been stolen from him, and made many excessive demands. In four weeks this man underwent a noticeable personality change. He quieted down, lost his symptoms, became very friendly and devoted. He returned to sea and when last heard from was doing well. Therapy was confined to group talks.

Severe cardiac disturbances defined a distressing autonomic condition in a 35-year-old Swedish man who showed an extremely rigid, suspicious personality. Ectopic beats, giddiness, and heart consciousness had confirmed in his mind that he had a serious heart ailment. Insomnia, loss of appetite, and general agitation leading to crying spells rounded out the picture. He had been in no actual torpedo-ings but for one and a half years was under constant strain of expectancy of attack, having seen bombings and submarines at a distance. The symptom picture began with dizziness on the last trip out, which was entirely uneventful. This man was untouched by either individual or group therapy, but showed a complete right-about-face when a hunting trip into the nearby hills was arranged for him, a reminder of boyhood days. He brightened up, showed less hypochondriacal concern for his heart action, improved in appetite and sleep, and two weeks later left to go back to sea. The exact degree of improvement was difficult to gauge.

Individual catharsis seemed to be the most helpful factor in the case of one man who had been through two severe torpedoings, the second leaving him with a form of bronchitic asthma. He attributed this to a new kind of torpedo exhaling sulphuric gas. But his dyspnea was not adequately explained and was worst at night when he would wake and scream out. Nightmares of being sucked down with a raft and chased by devil fish were distressing. Diffuse anxiety, buzzing and humming in the ears, and sensomotor disturbances were present. Claustrophobia was marked and was attributed by the patient to having been locked in the boiler room during one of the

torpedoings. Improvement, which was gradual, was complicated in the end by alcoholism. This man showed extreme conscientiousness about going back to sea and looked upon himself as a deserter for not returning at once.

An exaggerated sensomotor picture was presented by a 30-year-old deckman who was first thought to be a paranoid praecox case. On sudden noise he jumped high into the air, often knocking over furniture. There were terrifying repetitive dreams of the original catastrophe, which had been unusually severe. He was blown several feet off the deck out of a sound sleep and thought he was dropping down the stack into the boiler room. Scalding by steam was added. The trauma lit up old paranoid formulations. Diffuse anxiety was marked, with vagotonic disturbances. Auditory and visual hallucinations with queer psychosomatic experiences and persecutory delusions followed. Individual therapy alone would touch him and he was seen three times per week. He developed a strong transference to the house staff and improved to the point where he wished to try it on the outside. On leaving the home he became frightened and put himself in the detention ward at Ellis Island. He has since been released but is still quite ill and remains a therapeutic challenge.

A 42-year-old Philippine cook and messman was knocked flat under a table by the torpedo explosion, which was his first. After some weeks he suddenly noticed that he was so weak he could not lift a bucket of water, that he jumped at noises and felt someone behind him, and that he had cramps in the stomach. He had dreams in which he stabbed a friend who had been dead 15 years, and others in which his ship capsized upon him. There was hysterical deafness. A cheerful, jolly fellow, he played the guitar and smiled all day long. He looked optimistically upon his condition and felt he would soon be well. He returned to sea after two weeks, greatly improved. Two therapeutic interviews were considered sufficient in his case. Past history showed unusual stability.

A new and recent addition to the therapeutic armamentarium has been the use of semantic group discussions on a smaller scale. Selected groups of five or six are brought into the physician's study for a talk, and an informal seminar atmosphere is encouraged. A topic such as fear, for instance, is chosen and its semantic possibilities exploited. Each man is asked to contribute his own definition of the theme word, and the individual offerings, generally striking in their discrepancies, are utilized as points of departure for discussion. The

talk is finally led back to a central point; real fear vs. irrational fear, and the ways in which a word or concept can be used by the psyche for good or ill. In this informal atmosphere the men tend to unfold eagerly, and the therapist is hard put to it to function adequately as a referee. This therapeutic approach combines the advantages of catharsis with a didactic element. The whole symptom picture can also be attacked through this channel. At a recent seminar, each of the five present were asked to say what came to mind with the word "symptom." No. 1 said, "Jitters, unconscious fears." No. 2 said, "Afraid sit down at table, shaking." No 3 said, "Sensitive. Be scared of a thing supernatural." No. 4 said, "Noises." No. 5 said, "Shortness of breath. They gave us such a run-around; the ash cans and the feeding in the canteen." The mixed physiologic and psychologic symptoms mentioned gave excellent starting points for talk.

It is not right to leave the subject of treatment without mention of re-educational methods. Occupational therapy, the strengthening of psyche-soma through manipulative activity, was used to supreme advantage at Base Hospital No. 117 in the last war. The value of work, the physiologic and psychologic features that result from effort to overcome resistance, certainly cannot be overestimated. It is the conviction of the medical staff that it is important to teach the men that work in itself is curative, promotes sleep and relieves tension. To date, the problem of the utilization of work therapy in our rest homes has not been properly solved. Part of the difficulty lies with the seaman himself, who regards all the time spent on shore as dedicated to inactivity on the physical side. Hence an educational task lies ahead in gaining his interest and cooperation. Some of the seamen do expert drawing and sketching, and it is possible that this can be used therapeutically to ventilate specific traumatic experiences, as was done at La Fauche in 1918 with Army cases. Where a seaman is too sick to be returned to sea duty, measures are taken to interest him in another trade while he is at the home. The Oyster Bay Aviation Defense Training School has kindly offered its services to our men for courses in blueprinting and aviation mechanics. The men can step from these courses to excellent positions in the aviation defense plants and elsewhere.

Regarding the cases of chronic neurosis, it has been the feeling of the medical staff that it is justifiable to spend the major portion of available time with the cases that show the best results, the acute cases. That does not mean that the chronic cases go neglected, but

they are not in the first line of therapeutic fire. Much time goes to them nonetheless by reason of their exhausting demands, and it is fortunate that they are instructive and reward the efforts expended. It is the hope of the medical staff that treatment of the acute cases will lessen the need for treatment of chronic cases by preventing their growth.

The handling of cases at discharge is eased by the fact that the seaman is generally only too eager to get back to sea if he can, and conceives of the return itself as therapy. In this he rather differs from the soldier at the front. In addition, he needs to get back to sea in order to make money. The transition from the rest home back to sea is aided and abetted where necessary by the able and generous assistance of the social service department, whose experiences in contacting these men in their passage through the city in itself constitutes a chapter of medicine.

One final word regarding therapeutic aims. The treatment program has been organized by Dr. Blain with a consistent goal at all times in view, to give the seaman who comes to the rest center something that he can take away with him and use as a permanent acquisition. What is taught the men when they are sick is the same kind of thing that would be taught them when they are well. If a man walks into something that he does not know anything about, he is twice as afraid as if he were psychologically prepared for it. When he has something to grasp hold of, he is stronger. It is thus with the seaman who returns to his fighting front, the high seas. We want the patient not only to feel like getting back to work, but to take something with him as well.

CHAIRMAN RUGGLES: In the brief section on pathology and etiology, it came out several times there was a possiblity of divergent symptoms; that, of course, makes it possible there are divergent etiologies. And in seeing one at least of these patients here, it certainly seemed as if there might be a neurological complication.

Dr. Sherman has given us a very excellent presentation. Some of his cases were exposed to rather severe trauma. That brings to mind the possibility that we may have swung a bit far away from the conception of shell shock at the beginning of World War I, and that we may be seeing in some of these severe traumatic situations cases that have organic damage but also with some functional symptoms. I hope in the discussion of treatment Dr. Blain and his associates will speak of the question of neurological complications. We would

like very much to hear from one of our distinguished guests from Canada, Brigadier Chisholm. We hope he will say something on treatment, especially in view of his experiences with men returned from battle fronts.

DR. G. B. CHISHOLM: Dr. Ruggles, personally I thank you most heartily and sincerely for your invitation, and also on the part of my colleagues of the Canadian Navy and Air Force, to be with you and learn something here. There is one matter that I think should be given a little more consideration than it has yet received. It has been referred to. It is found in all fields of etiology and treatment and prevention. One goes back to the early days of the last war in the years before shell shock was noticed; one found that the thing that men could not stand was futility, frustration. The thing that was most difficult and broke most men down was sitting down under shell fire for month after month, and even year after year, in the early years of the war, at a time when the enemy had all the preponderance of fire power, artillery, airplanes, machine guns and everything else. Those very difficult times produced large numbers of casualties. Frustration in the Merchant Marine, the feeling of futility, being hounded across the ocean by a pack of German submarines without being able to do anything whatever about it, is emotionally very trying also.

We are finding now in the Canadian Air Force in England, which is fighting, that we are having very little breakdown at all, whereas in the Canadian Army in England, which has been suffering now for three years from the futility of inaction, we are having large numbers of breakdowns. The men are having no possibility of expression of their hates and their aggressive feelings.

It would be very interesting to know to what extent there may be any difference between the incidences of breakdown in freighters which on the one hand are completely unarmed and on the other in those which may carry airplanes or guns. It may be supposed that these men could associate themselves, gain some feeling of identity with the crews of the guns or the crews of the planes, which, as you all know, in some cases are carried on catapults and are prepared to be launched whenever necessary. It may be it would be worth finding out. I don't know whether anyone here, sir, has any information on that point. But it may be that the arming of ships will have a very useful effect on the sailors themselves.

During the early years of the last war, I was impressed by the

guilt feelings found in men who could not express their aggressions, sitting down under shell fire, piling up hates for year after year, with no place to go, which frequently made men turn on their superiors. They could do nothing about their hate of the enemy and they frequently became very critical and very aggressive toward their non-commissioned officers and officers. It might be that useful treatment could be found by helping these sailors to express their aggressions more freely. It might be that movies, for instance, taken of airplane raids on German U-boat harbors might be very useful indeed. If these sailors could feel themselves identified with somebody who is taking it out a little on the U-boats, they might be able to use up a great deal of their pressures. Distribution of souvenirs from destroyed U-boats might also be helpful.

I would like very much to know if anyone has any figures on the incidence of frustration reactions in various kinds of ships, armed or unarmed.

CHAIRMAN RUGGLES: Thank you, Brigadier Chisholm.

I hope the following speakers will keep in mind Brigadier Chisholm's question as to the incidence of war nerves on those unarmed and armed ships. I am sure we all want to hear again from Lieutenant Rome of his experiences in the Southwest Pacific; and probably more than any of the rest of us, he has seen cases early in their career and that have been emphasized in the matter of treatment. Lieutenant Rome!

DR. HOWARD ROME: Dr. Sherman has outlined a plan similar to the one which we had adopted at an advanced base hospital in the Southwest Pacific. Our cases were made up of our Marines serving as ground troops and a smaller number of Navy personnel in service on ships in the area. Apropos what Brigadier Chisholm had to say, the men who were constantly anticipating raids or action and yet, who after a period of eighteen to twenty months had never had action, had a much higher incidence of traumatic neuroses than did the men who were in actual combat.

The therapy we employed combined expediency with two other factors. One, of the use of sedatives to diminish their hyperirritable response to environmental stimuli and, second, the retraining in stable action relationships by planned direction.

Sedation was most important because it blanked out the noise

and action stimuli in the environment which could not otherwise be controlled.

Group psychotherapy has to be lived in constantly, not merely exposed to intermittently. Accordingly meals, recreation, group sessions and rest periods were planned for. As Dr. Sherman mentioned, assurance and solicitude were the supporting elements in the background. Since, in all military situations, security is wholly dependent upon collective action, the earlier in rehabilitation that the patient becomes aware of this and affiliates himself the sooner is he freed from his symptoms. In a group, security is gained by a mutual pooling of individual insecurities. The group becomes the reservoir from which all members are eligible to draw the additional security necessary to fulfill their personal demands.

Apropos what General Grant said, the physiological consequences of fatigue often assumed psychological significance and we felt that these patients were in a little different category. Help for these people lay mainly along the lines of aiding the normal recuperative function of rest.

The idea of not going too deeply into the psychopathological background we found extremely important. Not infrequently in our early enthusiastic attempts to bring about cures, we stirred up hornets' nests. Group psychotherapy in a large measure precludes this.

The plan of therapy as outlined by Dr. Sherman has my enthusiastic endorsement.

CHAIRMAN RUGGLES: Dr. Daniels, may we hear from you on your treatment experiences?

DR. GEORGE E. DANIELS: Dr. Ruggles, I am very sorry that the treatment of traumatic neuroses is something that I have had little medical experience in. I did have the privilege and opportunity, however, of seeing some of the men at one of the rest camps described. I was very much impressed with one thing; the readiness of these men to talk of their experiences. Now, it seems to me that this is perhaps one of the most crucial points in the whole treatment of this group of disorders.

It has already been stressed that in the present program for treatment of patients, there is made an effort as far as possible to follow along the normal sequence and let the patient take somewhat the lead in indicating how deeply the situation should be gone into.

This, it seems to me, is extremely important.

Dr. Blain and some of the others have stressed the effort, where it is possible, to glide over the disturbing experiences. I think as time goes on, however, it will be more and more necessary to pick out the patients which will need some further psychotherapy than what at the present time is being given, because of the possibility of later breakdown.

Now, to go back to this matter of the ability of the men to talk about their experiences—and this was simply at the table during mess. Fortunately, in the profession of seamen we have the tradition of being able and glad to spin yarns about adventures. This, I think is a very important tradition, because it gives an opportunity for therapeutic exploitation. As the men come back from these experiences, when they gather in groups to discuss their adventures or can be called upon from time to time to speak over the radio or in other gatherings, we have a natural type of psychotherapy operating.

What I was particularly interested in in the discussion of treatment, so far as presented by the professional staff, was the use of group therapy. This, I believe, will give a medium for therapy and a screening of cases which perhaps cannot be gotten in any other way. We have recently had occasion to go over some of the literature on group psychotherapy in preparation for its use in the present emergency. I hope a report on this subject is coming out in the April number of PSYCHOSOMATIC MEDICINE.

Now, in this the types of experience fall into two main categories, the inspirational or repressive approach to group psychotherapy or treatment and the analytic approach. Schilder has emphasized the importance in group psychotherapy of allowing the patients to bring out their own experiences, and I was very glad to hear Dr. Sherman say that in his groups or the groups that have been established this is possible to accomplish. This will give them an opportunity to pick out the individuals that need further individual psychotherapy, while at the same time in this initial stage there is a catharsis, a diffusion and repetition of their experience in a therapeutic manner.

Pratt and others that have had a great deal of experience in group therapy lay emphasis on the importance of having the star patients in a group go over material with new members. With men of the Merchant Marine, because of the heroic and constructive value of their exploits, a repetition is made more possible, whereas in some other types of painful experiences this might not be as possible.

Something has been mentioned about the necessity for getting

out aggression. Schilder, who had done more in the analytic approach to group psychotherapy than anybody else who has reported his experience, found that in a group very often the individual will bring out aggression toward the leader of the group, whereas he won't toward the same individual in his consulting room. Certainly not only through the use of moving pictures, lectures and in other ways, can the group be used as a therapeutic medium to promote emotional catharsis, but also as a most important vehicle for the building up of the morale and the development of techniques for meeting combat which have been stressed as an important factor. I believe it would act by way of prevention to hear experiences as adventures from shipmates for those who are going out or have come back and have not yet met with disasters. This would act as an important immunizing procedure for them.

CHAIRMAN RUGGLES: Thank you, Dr. Daniels!

Perhaps Surgeon Commander Mussen might answer Brigadier Chisholm's question. We would like to hear from him.

DR. R. W. MUSSEN: My interest in this matter of psychiatric casualties among merchant seamen was first stimulated by a very interesting talk which I had with Dr. Kubie several months ago. Before then, I had been more concerned with the physical well being of these men.

As he stressed the results of the hazards of war on merchant seamen, I was prompted to enquire whether he thought that this group was in this respect different from seamen in fighting ships. He said at once that he thought that they were: that the whole psychological background of the merchant seaman was different, that they often had no homes or family, and that the risks which they ran in wartime were more continuous and hazardous than those borne by the average naval sailor. In addition, of course, there is much less glamour, and less organised care and entertainment, which is looked upon as the right of the fighting services in wartime.

I think that there is a lot to be said for this argument, and it is a matter in which all of us who are connected with the naval services must take a large interest

I should like to mention two points only. The first is the question of fatigue. I have seen large groups of survivors after several land actions, and have been impressed by the importance of fatigue

in their general condition, and the necessity for adequate rest and sedation in many cases.

I think that the less you mention the word 'traumatic' in connection with the psychoneuroses of wartime the better, whether in the Merchant Service or in the Navy. It appears to me to be getting dangerously close to the term 'shell shock', as used in the last war in France. Someone has mentioned the occasional case of true commotional injury to the brain. This recalls an observation of Dr. Gordon Holmes at the British Shell Shock enquiry in 1920. He stated that a distinction which he had noticed between the case of true commotional injury on the one hand and the psychoneurotic on the other was that the individual with true injury was very much annoyed if he was put in with the so-called shell shock patients.

CHAIRMAN RUGGLES: Thank you very much! Dr. Wortis, would you speak on treatment and any experience you may have had with these commotional cases?

DR. S. BERNARD WORTIS: I have been seeing torpedoed seamen both at the Bellevue Psychiatric Hospital and at the United States Marine Hospital at Ellis Island. Most torpedoed seamen do very well, despite the severity of the stress of worry, anxiety and actual torpedoing. Most torpedoed seamen are anxious to get back to sea and do so. Only a small proportion of torpedoed seamen require hospital and convalescent care.

The number that come to hospitals with related head injuries, such as brain concussion, contusion or brain laceration, is small. Many of these have the usual symptoms of headache and dizziness which may be associated with other neurological signs. On the whole, one is impressed by the paucity of associated neurotic signs—as compared with individuals similarly injured in industry. This, I believe, is largely due to the patriotic feeling the seamen have that they are doing a dangerous but essential job. They are today socially accepted as heroes and this social blessing, plus their own conscious desires to help in the war effort, is partly responsible for the low incidence of neurotic casualties. We may well see an increase in neurotic symptoms of these men when the war is over. Some few of the torpedoed seamen may be putting on a front of toughness—they may be malingering health to show what virile fellows they are.

Several features strike me as important ones in the prevention of nervous casualties in torpedoed seamen. First and most impor-

tant is the need for strong, respected and understanding leadership. The captain and the ship's doctor are the most important people as regards the establishment of good morale or good stamina on board ship. If the men in command show no signs of fear or anxiety, the possibility of their developing in the seamen on their ship is much minimized. Anxiety and panic are contagious emotions.

Furthermore, what may look to the civilian psychiatrist like severe mental illness following physical and psychological trauma, is less ominous in war conditions where the factor of fatigue plays a most important contributing role. Generally speaking, we may say that the prognosis for recovery in cases of "war nerves" is remarkably better than for nervous and mental illness incurred in civilian life. Many fatigue states are misdiagnosed psychoneurosis.

When men know what they are fighting for, morale is high and neurotic casualties are low. It therefore would be wise to instruct our merchant seamen, just as is being done for our soldiers and sailors, what we are fighting for, and why.

Thirdly, when men are tired following severe traumatic exposure, the military physician should be instructed to insure adequate sleep. The sooner this is done following the onset of neurotic symptoms, the better the chance to rehabilitate the patient.

Finally, it appears to me that the merchant marine, during the war, should be incorporated into a regularly recognized, uniformed government service. This would improve the stamina of the men, give them formal recognition, improve the spirit of cooperation and work, and result in fewer nervous and mental casualties.

Dr. Lawrence S. Kubie: Dr. Ruggles, I have a few fragments of data that offer a partial answer to Brigadier Chisholm's question. Our numbers were small, particularly after weeding out unsatisfactory cases, so that our statistics offer nothing more than a lead. We found that the only vessels in which there was an outstandingly high incidence of severe disturbances were the tankers. On the other hand, the severity of disturbances did not correlate with the position of the man in the ship, whether he was below decks or on deck, whether he was asleep or awake, or various other considerations to which significance has been ascribed in the literature. Although the impression lacked full statistical validation, everyone felt that arming the ships and the men made all the difference that one would anticipate. Even a pistol, however ineffective, wrought a difference in the men's sense of helplessness, and relieved the awful strain of waiting.

Now I would add a word to the discussion of therapy. The point

I have in mind seems to me to have a significance which is both practical and scientific.

Surgeon Commander Mussen has mentioned the importance of fatigue, sleep, and sedation. Sedation has also been mentioned by Dr. Rome. This is the point I would like to pick up. In the first place, the general relationship of sleep to the psychotherapeutic process is a problem which has never been adequately investigated. In sleep some individuals pendulate back to a storm center of emotional stress which then persists through the following day, whereas other individuals in their sleep achieve a state of relaxation and rest, so that they seem to start the next day with a slate which is cleared of the emotional storms of the preceding day. Indeed, this is one of the differences between the individual who gets sicker and sicker and the individual who stays well under stress: and we do not understand this difference because no one has studied it. Just as no one has studied the difference between the nightmare whose terror is over as you waken, and that whose terror persists.

In our own experimental work it is becoming clear that in the process of falling asleep, and again in the process of waking from sleep, and also recurrently during the course of sleep itself whenever sleep lightens, a state of partial sleep occurs. We don't know quite what to call this. It is a hypnoidal state, or a state of hypnagogic reverie. In this state the mind is busy trying to rid itself of the unresolved tensions and terrors of the preceding day. This is why during the process of drifting into sleep or while slowly awaking, the sailors are most likely to suffer from terrible nightmares. These dreams begin as an effort to find a happier ending to the horrors in which so many of their shipmates have perished; but the rising terror wakens them before they achieve that goal, so that they waken in a frenzy of unresolved somnambulistic panic.

This leads to one obvious and practical suggestion, namely, that in planning any regime of treatment for these men, their sleep should be carefully controlled and supervised from the moment of their rescue, even before they begin to show any emotional distress. Since the passage between the waking state and the sleep state is their most vulnerable moment, they should be precipitated into sleep as swiftly as possible, by using the most rapidly acting sedatives that we have, such as seconal or pentothal. And since they should be maintained in profound sleep throughout the night, the quick-acting sedative should be combined with those which act more slowly and for a long period, such as the barbital group. And when the patients are

to waken, they should be wakened rapidly and in such a way as to bring them back quickly into contact with reality, so that they don't again pass through this half-waking, half-sleeping hypnoidal state in which they tend to relive and to reactivate the original panic. Every sailor that I have seen who has developed severe daytime panic states has gone through a prior period in which he established this pattern during a poorly handled sleep regime immediately after the catastrophe.

Such a regime implies also that there should be close supervision of the men as they are falling asleep and as they are waking from sleep. In fact, it is best not to allow the men to waken by themselves. They will waken too gradually. It is better to rouse them from a profound sleep into full activity. Furthermore, such a regime should be maintained for weeks after the experience, precisely as we give luminal or bromides to an individual who had had a head trauma, as a prophylactic against the later evolution of organic disturbances.

In emphasizing the importance of sedation and an adequate supervision of the sleep regime in the prophylaxis and treatment of traumatic war neuroses, we should not overlook the correlative importance of making it possible for the patients to ventilate openly their pent up feelings and to relive and recapture forgotten details of what they have been through. Catharsis and the penetration of amnesic barriers are both poorly understood concepts and processes for which excessive claims are often made. We must guard ourselves against dogmatic statements about their value. We don't know enough about either process. The unsolved questions which center about them go to the roots of the problem of all psychotherapy. We don't know why it is that certain types of emotional discharge make an individual well, whereas other types of emotional display such as depressions or anxiety states are self-perpetuating disturbances. Similarly we don't know why it is that the recovery of data which is lost to conscious memory causes a disappearance of symptoms in some cases, and in others cases seems to have no therapeutic action. These are problems which are in need of all the objective investigation that we can give them; but about which we have no right to make dogmatic assertions at this time.

DR. A. A. MARSTELLER: It seems to me that in considering the subject of treatment the terminology is a most important consideration, certainly throughout our Navy. Throughout the Navy,

to the average bluejacket, the diagnosis of a psychoneurosis is synonymous with a psychosis. Likewise, a neurosis. So that even if the patient eventually gets back to duty status, he feels that he is stigmatized. He feels that his shipmates and all know that he has been in what they call the "nut ward." He is just unable to face the situation. So that I was very glad to hear "war nerves" used. I don't know whether that is entirely satisfactory from a naval standpoint, because it still carries a certain implication with it. I would like to hear some more discussion about that.

CHAIRMAN RUGGLES: Colonel Halloran, will you say a word on that?

DR. ROY D. HALLORAN: I have been very much stimulated by the various discussions about the treatment of the neuroses and the various elements in which the neuroses occur because it seems to me that the questions of etiology and treatment depend, to some extent, upon whether there is a difference between the effects of the elements in which these neuroses occur. If the effects of sea, air, and land fighting are different, then perhaps we should and may expect some different symptoms which require different treatment. There is one factor which I think we should consider very seriously and that is the factor which has been touched upon—selection.

The Army differs very radically from the Navy and the Air Force and, of course, the Merchant Marine, in the fact that the men are not selected; that is, as a rule they do not usually come in voluntarily There is an element of selection, of course, at induction. Whether that voluntary element in other branches of the service will make a different picture as far as the risk is concerned—as far as precipitating factors which may result in real neuroses when the battle line is reached, or before,—depends upon whether a volunteer constitutional factor exists and how important it is.

It has been said here today that there has been some question as to whether the constitutional factor is important. Now there are some experiences which have come out in some fairly recent conferences abroad, which indicate that along the present battle lines there are those who have what is known as good constitutions and those who have what is known as poor constitutions. In those having the good constitutions it has been found that by sedatives, and rest for twenty-four to forty-eight hours, plus adequate diet, about a third

of these can be returned to duty. But they must be reached immediately.

Military forces are equipped with certain sedatives so that the neurotics can be given some sedative promptly and put to sleep. It is found that in these good constitutions the condition improves, but in the poor constitution soldiers have to be removed backward to the larger centers and the element of recovery is not so great. I think that this experience seems to indicate that there is an argument for a difference in constitutional background which makes some individuals more susceptible to war neuroses than others.

It is true that in the Army, thus far, we have not been so much on the combat line as the merchant seamen and the Navy. Most of our difficulties have been in the training period. There is an element of protection in this processing, because before the front line is reached many of the susceptible are removed.

Possibly you are aware that we have initiated a nation-wide development of replacement training center mental hygiene units, or consultation services as we usually call them. These are manned by a neuropsychiatrist, psychologist, and a psychiatric social worker and operate apart from the hospital, in close connection with the classification section. The purpose of these units is to educate the unit commanders in the early recognition of mental disorders and to provide early treatment and disposition. Some very beneficial results are accumulating and already the work of the hospital sections has been considerably relieved, since many may be retained in regular service rather than hospitalized. The neuropsychiatrist uses considerable ingenuity in giving insight to the line officers, chaplains, provost marshals, and general medical groups so that early recognition may be effected.

I may say that the neuropsychiatrists in charge of these units have been carefully selected and trained at previously established units so that they have some idea about the method of organizing these services.

A school of military neuropsychiatry has been established at Lawson General Hospital, Atlanta, Georgia, under the directorship of Colonel William C. Porter. There a group of officers from all the service commands, the medical pools, and the Air Forces attend courses in monthly quotas. Discussions and lectures are held on clinical and administrative subjects and the new developments along mental hygiene lines are freely discussed.

I feel very happy to be here and to represent the Surgeon General

of the United States Army today. He hoped to get here but was unable to do so. We appreciate that if we are to derive some benefit, we all must work together. We must all observe these and other experiences about which we are hearing this morning, compare notes, and work together in studying these situations from time to time so that we can take advantage of these investigations as they pertain to cause, prevention and treatment.

CHAIRMAN RUGGLES: Thank you, Colonel Halloran!

I would like to say just this in connection with what Colonel Halloran has said about pooling our ideas and swapping our experiences: The half-day session at the May meeting of the American Psychiatric Association will be given up to these problems of the neuroses in the Merchant Marine and also to the psychiatry in the Navy and in the Army. Perhaps I shouldn't use the word "psychiatry" in this connection, but those common problems of the central nervous system will be taken up and it will be a very excellent opportunity for sharing our experience and of determining, following this conference, other methods of treatment.

Dr. Kelman, may we hear from your experiences at the Marine Hospital?

DR. HAROLD KELMAN: We in the marine hospitals have an excellent opportunity to study the traumatic neuroses in civilian life as well as subsequent war hazards.

In the past seven years I have been able to see a great number of these cases. This includes people of all nationalities, races, colors, creeds, people from all over the world, from all financial levels, through the depression and now into a period where there is opportunity to work. I have been impressed with the fact that you can find exactly the same things following traumatic experiences in civilian life as in war. Over-emphasizing the special nature of the traumatic neurosis in war or civilian life as differentiated from neuroses not subsequent to obvious trauma confuses rather than clarifies. In fact, I believe that trying to derive a general theory of the neuroses from a particular syndrome is reversing the process.

In the Neuropsychiatric Service of the United States Marine Hospital at Stapleton, of those cases of traumatic neurosis in seamen seen in the last six months, that were sent to rest homes, there were four who were considered to have had an obvious previous psychoneurosis. To me, their war trauma was just another incident. Then

there were seven more whom I considered to have had a traumatic neurosis following bombing or torpedoing. Two of these had in addition what is known as "immersion foot."

We have treated torpedoed seamen in the early days before ships were convoyed or had their own guns. The symptom picture was the same then as now. I feel that absence of equipment and training for self-protection exaggerates the seamen's feeling of helplessness. Any material or technique that favors a greater resourcefulness of these seamen while they are on the boat, anything that favors group cooperation and group participation, anything that enhances their importance on a job with the equipment to defend themselves, I think is of paramount importance.

Fatigue is an important and outstanding symptom in the traumatic neurosis but is only one of the symptoms of this disorder. Symptomatic treatment is adjuvant, while psychotherapy is basic therapy. Various combinations of sedation have been used. The fatigue factor is prominent in men coming off ships having gone through danger zones, among men in the defense plants who have worked very long hours, and in veterans of World War I.

Some very interesting observations were made of fatigued patients. On admission they often say that they are so fatigued they cannot sleep. We use doses of phenobarbital up to grains one with tincture of belladonna minims ten, four times daily, and barbiturates at night. Sometimes, to break the vicious circle of over-fatigue and sleeplessness, we may use, intravenously, seven and one-half grains of sodium amytal and even up to fifteen grains of sodium amytal. Such doses should be used only by those experienced in the use of this medication, because very frequently one may get respiratory difficulties. I have found that once a fairly sound sleep is established, they go into an almost stuporous state. They may remain in this type of slumber for about seven or ten days and then natural sleep finally supervenes. They are then put on graduated activities of all types. Balneotherapy is of considerable value.

Our emphasis in this hospital is on the use of medication, diet, and physiotherapy and some psychotherapy. The ward atmosphere is conducive to the feeling that they have a right to their illness, that it is quite legitimate and that we expect improvement. This feeling is nurtured by the ward personnel and favored by the frequent departure of men who have recovered, back to their former occupation as seamen. We have also noted something that has been emphasized many times here, namely, that they are anxious to get back to sea.

The point also has been made that we find many people who have adjusted in civilian life and yet in time of war have developed a traumatic neurosis. I think the term "adjustment" is a somewhat rigid term. If we would think in terms of a creative spontaneous form of life, with satisfaction, some happiness, and some sense of participation, we would have a much better criterion. There are many people who, from a social viewpoint, are well adjusted. They have good jobs, have been successful, are family men and active in their communities. Socially they are adjusted and yet they are really basically very frustrated individuals. It has been my impression, as has been pointed out by Dr. Kardiner, that the stammerers, the epileptics and those with severe autonomic disturbances would be the types of individuals who are prone to develop traumatic neuroses. They cannot stand the break-up of the defense systems caused by the trauma because of a rigidity of their character structure. The feeling of falling to pieces which we see in working with psychoneurotics whenever any kind of defense, minimal or maximal, is broken through, is, I believe, present in an exaggerated form with patients who develop a traumatic neurosis. Their lack of flexibility makes them more susceptible.

CHAIRMAN RUGGLES: Thank you, Dr. Kelman!

The work at La Fauche in the first war was referred to by Dr. Sherman. Perhaps this war is so different from the last war, we can learn no lessons; but several speakers have intimated there were some common principles running through the whole situation. I remember very well the work of Colonel Hurst of the British Army in the last war, who made use of the retention in the ward of star patients for the group therapist and for setting the atmosphere, which Dr. Blain has so well done at the rest homes, for the improvement of the patients. Dr. Roscoe Hall took part in the treatment at La Fauche.

DR. ROSCOE HALL: Perhaps I might take advantage of General Parran's invitation to talk about some earlier topics to which reference has been made. It is well to hear so much stress laid on the immediate situation and not so much on the background. We still hear the word "predisposition" which, after all, we know very little about.

I should remind you of two studies of predisposing factors in psychoneuroses that show how important is the point of view of the observer. In THE LANCET of 1918, Dr. Julian Wolfsohn reported such

a study of British soldiers at the Fourth London General Hospital. He found that more than 70% of them had a family history of neuropsychiatric determinants and that more than 72% of the patients had a history of neuropathic constitution. Dr. Sidney Schwab, Medical Director of Base Hospital No. 117 in the A.E.F., in a similar study found neuro-psychiatric determinants in family and personal history in some 30% of the patients. The difference of some 40% obviously was in the point of view of the two neuro-psychiatrists — unless one brings in nationality, which is absurd here. In other words, one has to look for what one wants to find or perhaps one won't find it.

Dr. Rado may remember that the other day at St. Elizabeth's Hospital he saw a patient, a chief water tender, who was on the U.S.S. Hornet from the time it was commissioned until it was sunk. This man was 38 years old and had had eleven years' service in the Navy and previously was a sergeant in the Marine Corps. For two months before the Hornet was sunk he was actively psychotic with a paranoid schizophrenic reaction — including the usual auditory hallucinations — c.s., s.o.b., etc., — but this psychosis did not interfere with the performance of his duties. On the day of the sinking he did an excellent job as a chief water tender and, as many of you know, that is not a sinecure. I happened to take him to a medical students' clinic and one of the students asked him, "Did you hear these voices during the day of the battle?" The chief, who was a very laconic individual, said, "No. I was kinda busy then." Later on, after his rescue and arrival at San Diego, he began drinking heavily and his psychotic reaction increased and a near-panic state ensued. He has now made a very good recovery.

I think the point that Dr. Schwab made some time ago at one of the National Research Council Committee meetings is pertinent — that it is not entirely a matter of ruling out the neurotics from the armed services but also of ruling out the neurotics who are not going to be able to make a satisfactory service adjustment. Many neurotics make a much better adjustment in the armed forces than they ever did in civilian life. As someone said this morning, perhaps a number of men become merchant seaman because they are neurotic in the first place. Dr. Kubie also spoke of how much more comfortable many merchant seamen were at sea than on land. I am certainly not advocating the employment of neurotic individuals as such, but I believe that we could well afford to pay attention to their assets as well as to their liabilities.

I thought that the general program of therapy that Dr. Sherman outlined was excellent and much in keeping with the spirit and practice of Base Hospital No. 117. I believe that one of the most important factors is the personality of the entire staff. In the A.E.F. many of us soon learned that time and care spent in the selection and training of top sergeants were far from wasted.

I will conclude with a word about a belief that so many individuals have found of comfort to them. That is pure, rank fatalism, and expressed in doughboy language it was the familiar "if a shell has your number on it, it will get you." The chief water tender that I referred to spoke spontaneously of this belief. I may remind you that some of the finest soldiers in the history of the world were fatalists. As a specific example, the Mohammedans who gave the Crusaders many memories. The British have not forgotten Gallipoli. It seems to me that we, as psychiatrists, neglect a factor that therapeutically so many persons have found useful in times of stress and danger.

CHAIRMAN RUGGLES: We still have adequate time for the completion of this discussion on this most important section on treatment. I would like to hear Dr. Overholser.

DR. WINFRED OVERHOLSER: One or two thoughts have occurred to me in connection with the comparison between the problem of the enlisted men in the Navy, and those in the Merchant Marine. One of them is a semantic problem, perhaps. It has developed in the Navy and the Army that the term psychoneurosis is essentially synonymous with discharge. That is one reason why the Navy and the Army enlisted men or officers dislike very much to come to the attention of the psychiatrist, for fear that a diagnosis of this sort will be made, which will mean in turn a threat to their security. It is one reason in view of that fact, which can't be denied, that probably we ought to coin some new term. I am not sure that war nerves is the best or fatigue syndrome or whatnot, but something, just a new word. After all, that is one of the principal pastimes of psychiatrists, perhaps. (Laughter)

In the case of the merchant seamen, there are two factors involved: one that he has no opportunity for compensation, but his pay is stopped while he is laid up; on the other hand, the history of having been even in a hospital or in a rest home with a diagnosis of psychoneurosis is not going to militate against his getting another

job. In fact, I rather guess sometimes some of these men go back to work before the doctors would recommend it.

DR. PARRAN: May I ask Dr. Overholser a question? At St. Elizabeth's Hospital, Dr. Overholser has both Navy patients and Merchant Marine patients. Do you detect the differences which have been suggested, and by other speakers rather denied, as between the reactions of those two types — reactions as patients?

DR. OVERHOLSER: Since Pearl Harbor we have had only about ten merchant seamen at Saint Elizabeth's, ranging in age from 21 to 68. Six of the ten were diagnosed as schizophrenia; the rest were scattering in diagnosis. Most of them had conditions of rather long standing, as compared with the Navy patients, many of whom show acute situational states. The factor of rigid military discipline, which seems prominent in the Navy cases, is of course not present in the merchant seamen.

CHAIRMAN RUGGLES: Thank you, Dr. Overholser!

We are honored in having here one of the Flight Surgeons of the Canadian Flying Corps. We would like very much to hear from him.

DR. C. G. STOGDILL: My work in the Air Force has been entirely concerned with selection, so I don't feel that I have a great deal to contribute to this discussion. One thing I would like to mention, however, following a remark of General Grant's. I have been told that in the detection of what is called "flying stress" in the Royal Air Force, the men who are recognized by the M. O's as showing symptoms indicative of "flying stress" and are then taken off flying for a time are likely to return to flying. Whereas, of the men who are not detected before they themselves come and ask to be taken off flying, a large proportion do not return to flying.

How applicable this is to the merchant seamen problem I don't know, or whether there is any possibility of recognizing the men who are showing signs of stress.

CHAIRMAN RUGGLES: Dr. Brill!

DR. A. A. BRILL: I just wish to make a few remarks apropos Dr.

Kubie's statement that the patients are most nervous as they fall asleep and when they wake up, and he thereupon suggested prolonged sedation. Now, long ago, when I was still worrying about my patients' insomnias, I tried to find out why they couldn't fall asleep. I then found that the popular conception of counting sheep in order to fall asleep is based on psychological facts. For my insomniacs were kept awake because they could not center on one idea. Their minds wandered from one idea to another, and as they couldn't center on one interesting idea, they couldn't fall asleep.

I then suggested that they should center on one idea, which was important to them. In addition, instead of giving them sedatives, I gave them some tonic, usually a fiftieth of a grain of strychnine. This overcame their incapacity to adhere to one idea and, believe it or not, many of them were actually benefitted by it. I merely offer it as a suggestion.

Just one more minute, apropos Dr. Overholser's suggestion to placate the Navy by inventing some new term for psychoneurosis—I cannot see why we should be afraid of telling the patient he is nervous. We have been trying all these years to educate the public that there is no crime or ignominy in being psychoneurotic. Why should we now invent a new word for it, why should we run away from the truth? Why not educate the naval authorities to the fact that it is not a crime to be nervous?

CHAIRMAN RUGGLES: There is just a minute left. I am going to ask Dr. Blain to close this session. But there is time for one more speaker before that, if anyone has any questions or anything to offer.

DR. LESLIE H. FARBER: I would question Dr. Sherman's statement about the relative lack of morale in the Merchant Marine, as compared with other branches of the armed forces. My experience has been just the opposite. The merchant seamen I have seen at the Marine Hospital in Norfolk have had unusually high morale, which I had attributed partly to their unique morale-building agency, the National Maritime Union. I think it is unfortunate that no one has so far discussed this element in morale.

From what I have observed, the union operates efficiently as a highly protective parental organization which not only protects the rights and privileges of its members, but actively encourages and

rewards both individual and group heroism. Even while in the hospital, the seamen maintain contact with their delegates. In fact, many of them regard the union as the most important single relationship in their lives. Since good morale is one of the most important safeguards against neurosis, as well as a primary factor in its treatment, it seems to me that this program would have to include a close, cooperative working arrangement with the union.

DR. EDWARD A. STRECKER: Dr. Ruggles, I would like to ask Dr. Blain if he has time to touch one point which seems to be the most important point in the therapy and has a direct relationship with chronicity, and which is obviously a handicap to the Merchant Marine. I refer to the possibility of establishing more immediate treatment, directly on some of the ships, possibly through men who are trained a bit in first aid. Perhaps quicker contact could be made with hospital ships or other agencies.

CHAIRMAN RUGGLES: Thank you, Dr. Strecker!

I am going to ask Dr. Blain also, in addition to that, because I don't know in my ignorance whether the Merchant Marine has any chaplain service at all that might be utilized in this way, but if you would speak of that, I would appreciate it.

Dr. Menninger has a word he wants to bring us.

DR. KARL MENNINGER: I haven't had any experience in treating these individuals with the anxiety precipitated in this dramatic way, but I spent the early hours of this morning cruising around over New York in a snow storm, unable to land, and thus made some personal observations on anxiety.

I have recently had an opportunity to study one of the captains of one of these merchant ships, which is the background for some comments that I would like to make on Dr. Sherman's paper. I thought his report was extremely interesting, but it seemed to me that something more might be made of the point that Brigadier Chisholm developed, a principle of therapeutics that we all know but are apt to neglect. That is the principle of dispersing aggressions in some acceptable way. I was impressed, too, with what Dr. George Daniels remarked about the ease with which in group therapy the leader was singled out for such discharges of aggression.

I am particularly interested in group phenomena and in this discharge of aggression toward the leader of a group, not only as

president of a psychiatric organization but also as a clinician. In our clinic, this device is regularly used as a method of treatment. It seems to me that we could give quite a little more thought to two aspects of that; (1) how such aggression can actually be encouraged, endorsed or utilized therapeutically; and (2) what becomes of the aggressions in those instances in which all symptoms subside under a regime which is entirely benevolent and in which the whole element of aggression seems to evaporate magically.

In most institutions where group therapy is in practice, one hears a great deal of "griping" and it is the impression of some of us that this is a very healthy device. In our own institution, we encourage "griping". I read somewhere that the army encourages "griping"; whether they do or not, we all hear a lot about it.

Now, what is the therapeutic effect of "griping" and what is the prophylactic effect? The latter we might discuss this afternoon. The therapeutic effect, I think, is important. What I am most impressed with is that it is difficult to find leaders who are able to take it. It seems to me that as medical men who are in the position of being therapeutically helpful to groups providing we can take the criticism and the abuse and the aggressions which we know are not intended for us, but which arise out of the anxiety and the freed aggressions which these acute illnesses precipitate. If there could be some general recognition that this a part of the process, then it might enhance the therapeutic effect by diminishing our defensiveness. My impression is that the doctor, not always remembering this or not always knowing it, is sometimes so defensive against the aggressions that are directed toward him as leader of the group or leader of the treatment, that the defense reactions on his part unintentionally defeat a good deal of the therapeutic program, no matter how ideal and intelligent it may be.

I was going to make some remarks about my captain, but I will do that this afternoon, if I may, in connection with prophylaxis.

CHAIRMAN RUGGLES: Thank you! Dr. Blain, will you conclude?

DR. DANIEL BLAIN: I might say that it was part of our idea to start out with a certain subject, and not to digress too far in the discussion, but that as the day went on, every subject would merge with the subject preceding it and so on. So that this afternoon we may expect to hear something about practically everything connected with the whole subject, even though we are always talking about the

general subject of prevention. I have a feeling, now that we have had a couple of laughs in the last few minutes, that we have begun to warm up to this subject. I am looking forward to the afternoon with keen anticipation.

Several questions I can answer right now. One is in regard to neurological checkups. Every patient we have is checked previously by doctors of the Public Health Service in the Marine Hospitals or the Marine Clinics. We are forearmed with the findings on the neurological side. I am not in a position to give you any information on the subject. We have had, so far, 300 cases. Our program has been gathering momentum until only two weeks ago we opened a center in Louisiana, and next week we will open one near San Francisco. So that in the next two or three months, we will probably accumulate a great deal more data.

I think that when the May meetings are held we will be able to give, in formal papers, some real conclusions founded on quite a large amount of material.

We tried to break up our group thus far, but the cases are really so few when we come to divide them into small groups, that we have no inclusions in this respect that we can even talk about at the moment.

With regard to the armed ships versus unarmed, I think in our records we will be able to find the answer to that question. There is no question but that the men talk about it all the time. "Well, I was on a ship that wasn't armed." But more recently we don't hear that so much. That is correct, isn't it, Dr. Sherman?

DR. SHERMAN: Yes.

DR. BLAIN: The doctors are seeing the cases. I don't see them so much any more. But the real point at issue is whether the people of the United States are looking after the seamen and are interested in them or not. Part of looking after them is putting guns on their ships and part of the whole morale problem, therefore, is brought up in this general subject of whether they do better with arms or without arms.

I want to say while I think of it that we are handicapped, Doctor, because Dr. Howard Potter, who is on a half-time basis with us and in charge of all the work in the New York area, unfortunately is laid up with laryngitis and couldn't come today. I want you to know he should have been here and we count him as one of our mainstays in the whole program.

With regard to cooperation with the unions, I know from the history of the Orient, that in China they got away from the government by forming their own trade guilds, looked after their own affairs, took care of a great many of their own troubles.

The merchant seamen have done exactly the same thing. There are some ten or fifteen different maritime unions.

I will say that the unions themselves are very vital factors in the morale of the seamen. They have done, I think, a great deal for the seamen and certainly they are doing a great deal now in the way of services that are given to the seamen and in adjusting grievances. They are very important. We cooperate with them very closely. We see their leaders continually. We have patients referred by them. They have come out to our places, and we foster the brotherhoods that they happen to belong to, no matter what it is, in every way that we can.

There are a small number of seamen who don't belong to any union, and a larger number of officers who don't belong to a union. As far as we are concerned, we don't care whether a man belongs to a union or not. We don't ask him, but we generally find out sooner or later.

So, eventually, I think we will have some figures on that matter.

Dr. Strecker's question with regard to earlier treatment, I alluded to briefly. It is theoretical, of course. We are preparing to put material on ships to get these men ahead of time. That is part of our prevention scheme.

As to the question about chaplains, the seamen themselves publicly and through their leaders say they don't want anything to do with religion. That is true of most of the unions. We didn't pay too much attention to that. On the other hand, we didn't do anything about it. We let the neighborhood influence our centers as the neighborhood wants to influence them. The result is that preachers and priests have come to all of our homes and the men are welcome to see them or not, as they please.

I was very much interested to find about three-quarters of all our seamen go to church every Sunday. It is entirely up to them. They get good spiritual care, because it is there if they want it. If they don't want it, we take a neutral attitude on the subject.

I think that is about all at the moment, Doctor. Maybe before the end of the day I shall have more questions to answer.

CHAIRMAN RUGGLES: Thank you. That concludes our time,

and I will turn the meeting back to the Chairman, Dr. Parran.

(Surgeon General Parran resumed the chair.)

CHAIRMAN PARRAN: Thank you very much, Dr. Ruggles!

Before recessing for lunch, I would recall that, as was stated in our invitations to you, this meeting is made possible and certainly made much more successful as a result of the cooperation of the Josiah Macy Foundation.* I should like to recognize Dr. Fremont-Smith, of the Josiah Macy Foundation. Have you any accountments you would like to make?

DR. FRANK FREMONT-SMITH: Thank you, Dr. Parran. I simply wish to tell you how delighted we are that you are here and that you have given us the opportunity to collaborate with you and with the Academy. Dr. Rappleye, president of the Foundation, telephoned me a little while ago to say he had been called to Washington, and wished to express to you and Dr. Blain his regret that he could not attend.

*Financial support for the Conference was also provided by the War Shipping Administration and United Seamen's Service.

PREVENTION

AFTERNOON SESSION

PREVENTION

The conference reconvened at 2:30 p.m., Eastern War Time, Surgeon General Thomas Parran presiding.

CHAIRMAN PARRAN: We shall continue the discussion this afternoon on the subject of prevention. The leader of the discussion will be Dr. Karl Bowman, of the University of California.

DR. KARL BOWMAN: Dr. Parran, Ladies and Gentlemen: I am informed that in the discussion this afternoon we can bring in all of the subjects that we have discussed before; so that you should feel free to bring in anything in the way of etiology and pathology and anything in the way of treatment. We shall focus on prevention, however.

The problem of the prevention of the fear neurosis or war nerves can be presented, of course, from many angles. I hope that is what we will be able to do this afternoon. Unfortunately, in psychiatry prevention is not as simple as is the prevention of certain physical diseases like typhoid fever or smallpox, where we can inoculate a person with a dosage of a certain drug or serum.

We will start the discussion this afternoon by calling upon Dr. Grace Baker, who is the physician in charge of the Rest Center at Baltimore, Maryland, and who will be able to present her material from the practical standpoint of one who has had experience in working with this problem. Dr. Baker!

DR. GRACE BAKER: War neurosis is a prolonged fear reaction to war experience. It is an over-reaction, not an illness in itself. Any planning for prevention, therefore, should be directed toward preparing individuals with the physical and psychological means for adequately meeting danger. We all recognize that danger admitted better prepares an individual, certainly psychologically, to deal with it. The known is less feared than the unknown. Admitting the danger carries with it the implication that something can be done about it. It tends, therefore, to eliminate or prevent feelings of helplessness or despair.

False reassurances are out, but every possible means of safety

should be provided and made known to the seamen, with clear explanations of why they are useful.

I think the importance of explaining why they are useful is indicated in a story that was told me. As perhaps you know, every seaman is provided with a knife. This perhaps could make no sense to him unless he was also informed that the knife may be of help to him in case he is thrown into the water, in helping him to attach himself to a raft where he can hold on until he is drawn to safety.

I think the factor, therefore, of explaining why each thing they are instructed about, what the purpose of it is, is very essential.

Measures of protection, strictly speaking, fall into two classes. First, what can be done to combat the possible real danger. Second, what can be done to prepare the individual, physically and psychologically, to deal with it. This should include all the unusual common sense rules toward achieving and maintaining good physical and mental health.

The basic principles should be directed toward building self-confidence, a sense of security, that is, a good healthy sense of self-esteem.

We all know the value of attention to any physical difficulties. Any physical ailment can prove a great irritant when we are under any strain. Attention to fatigue is particularly important. Regular furloughs are indicated. Frequent, if possible, but not for too long duration.

One suggestion would be recreational camps. Here men would be with those they are accustomed to, but if possible, outside visitors should be interested, which will tend to create a feeling that the men are respected members of the community.

If at all possible, individual conferences with the men should be held to provide an opportunity for discussing any of their worries. We all admit the value of discussing a problem. It creates a feeling that someone cares and many times something can be done to ease the worry.

I think the experiments in industry have proven the value of this. As you know, various experiments in trying to increase the output of men and women during times of particular pressure like war have been carried on. They tried rest periods; they tried changes in lights and color and food, and so on. But they finally concluded that the individual conference with the man where he had an opportunity to talk over his problem seemed the most beneficial. I think the real

basis of this comes from the fact that he feels that his welfare is of importance.

In giving the instruction regarding methods of combating the danger, the teaching should be given seriously and with confidence. It should be accurate and detailed regarding every lifesaving device. That is, I think it should have to do with frequent and constant drills as to how to abandon the ship, how to seek safety in times of bombing, how to get the rafts off the ship, how to swim, how to get into the lifeboat, and then very particularly how he can protect himself after he is in the lifeboat.

Some experiments carried on by Dr. Mussen and presented to us by Dr. Willoughby, I think have outlined the problem very carefully and show the value of this procedure. The man should be informed on how he should behave once he gets on that boat, what is the value of food, water, sedatives, and so on. Such information has value, not merely because it may save his life if the danger strikes, but at the same time it tends to create confidence. If drilled properly and frequently, he is trained to react more or less automatically and intelligently. It acquaints him, however, not only with the means of safety available, but produces the feeling that someone is planning for his safety. It creates, therefore, a feeling that he is valuable. When he sees other men similarly instructed, it reassures him that if he should become incapacitated others are equipped to aid him. This avoids the sense of aloneness. Such group instruction and drill therefore seems essential.

In addition to these physical methods to aid him, instructions should include some of the physiological signs of fear. We should understand these signs not as evidences of dying but as good and healthy indications, since they are the defensive mechanisms of the body to warn us in times of danger. The anger which follows is also legitimate and desirable. To object to aggression, resent it, is the body's defense mechanism; we have to defend ourselves and it therefore is quite proper and desirable. Many of the symptoms in the men have developed after they have reached safety. Their histories indicate little apparent upset about the trying experience itself. They appear to be reacting to what they consider evidence of neglect or failure of the individuals with whom they come in contact to appreciate the difficulties they have endured. Every effort, therefore, should be made to include in our programs all individuals who deal with these men.

I have wondered if these complaints are the real cause of the

disorder, or are these delayed reactions due to the fact that a man is harboring the fear that he didn't do as well as he should in the crisis?

He should be met with a sympathetic attitude and an honest regard for the hardships he has endured, but the emphasis should be put on a healthy respect we feel for the courage he has shown. Some official recognition and reward in the way of a ribbon or a medal would be useful. For the man who is broken down in the crisis, treatment should be considerate and it should be frankly admitted that the illness is unfortunate.

In order to avoid long illnesses and particularly with the aim in mind of preventing recurrences, the emphasis should be directed toward discussing with him all the possible factors that might have brought about the unfavorable results. This frankness creates the impression that such undesirable reactions can be treated and prevented. Any coddling attitude such as high compensations or too much sympathy should be avoided. Breakdowns shouldn't pay. Don't dramatize the sick but the one who stood it well.

I think that one plea I should like to make, too, in understanding the seamen is something to do with how little we know about him. As far as I can see, the general public's chief point of information about the seaman is that he is a drunken sailor. I think it is very important to emphasize that when he is drunk, he is off duty; also, that the alcohol is very frequently his way of treating himself. I think we can't deny that in many cases it has usefulness. I think that this is a very important thing because in the alcoholic seamen that I have seen, there is marked sensitiveness to their alcoholism.

To sum up, in our training, therefore, we would attempt to emphasize the important methods of his physical safety which is so essential. In so doing we stimulate or create a sense of self-esteem and provide justified reasons for self-confidence and a sense of security. We emphasize, too, that anger and fear are justified, but not despair. In other words, to be alive is power.

CHAIRMAN BOWMAN: Thank you, Dr. Baker!

As many of you probably know, in setting up these homes, an attempt has been made to link them up with some medical school. This home in Baltimore is linked up with the Johns Hopkins Medical School, and so I think it is appropriate to ask Dr. Whitehorn if he has any further contributions to make at this time.

DR. JOHN C. WHITEHORN: My actual knowledge of these matters

is almost all by proxy through Dr. Baker, and I could only comment intelligently by echoing what she has said and by stating my reactions to the other discussions today.

One point stands out in my mind very strikingly. That is the very definite attempt on the part of every one to keep the treatment and preventive program on a highly practical basis and to avoid so far as possible too much meddling with the background of the patient. That has even reached in certain people's remarks the extreme of wishing to avoid any of the terminology which would seem to imply an unstable background. I think in that connection the work that Dr. Baker has done, with which I have been a little familiar, has shown the value of having a well-trained and experienced psychiatrist in a key position where the practical program of treatment and prevention can be scheduled and carried forward with somebody in position to see the cases that it won't quite click with and to provide other disposition for those.

I think if we were to schematize too simply the whole treatment program and turn it over to other personnel, we would miss just this important consideration.

CHAIRMAN BOWMAN: I am going to call next on Dr. Felix, who is teaching psychiatry to the officers and men at the Coast Guard Academy. He may have something to contribute along this line.

DR. R. N. FELIX: Mr. Chairman, I don't know exactly what I can contribute from my experience. I am a psychiatrist at the Coast Guard Academy at New London, Connecticut. My job is mostly concerned with selection and assisting in indoctrination of the reserve and the regular cadets of the Coast Guard who have their period of training at the Academy.

Perhaps I should remark that one difference which I have noticed between the problems that have arisen among the Coast Guard enlisted personnel and among the maritime personnel is a feeling of lack of permanence among the latter. I see the prospective licensed officers in a consultatant capacity while they are in the training school at Fort Trumbull; I think that was mentioned this morning. The merchant seaman is attached to a ship for one cruise and then may go to another; while our Coast Guard enlisted men, of course, are assigned to their ship for an indefinite length of time and remain as part of the ship's company until they are relieved. Therefore, they develop a certain bond, a certain feeling

toward their officers, which it has not been my experience to find among the maritime enlisted men in every case.

I don't know whether Dr. Menninger had something like that in mind this morning, when he started to talk about his captain, or not. I think there is something there worth delving into.

The Coast Guard enlisted man gets a certain amount of transfer, emotional transfer, to his officer. He looks upon him in quite a different way from how I have felt the merchant seaman looks upon his ship's officers, which brings up the point that perhaps as much attention should be paid to the selection of the licensed officers in the maritime service as we are trying to pay in the Coast Guard.

In my work in that respect, I am using a battery of tests, in which I am trying to find some help in selecting these men. Each of them also fills out a personal data questionnaire which I have found of great assistance. Incidentally, if the war lasts long enough—I now have data, a rather complete set of data of 1500 college graduates from all over the United States who have gone through the Reserve Officers' Training School at New London, and, without hoping the war lasts too long, I hope that I can run that up to 3000—perhaps I can find something worth while there.

In addition to this, every prospective officer, whether he be reserve or in the regular program, is given a personal interview. In the Reserve Training School, there are about 275 entering every month. We have a four months' course. I see them for only ten minutes on the average. However, on that basis I am able to draw some conclusions probably somewhat snapshot in nature about the men, aided and abetted by my psychological and adjustment tests which I try to give them. I am using the Bell personal adjustment inventory, the American Council of Education psychological test, the Minnesota form board test, and a mechanical aptitude test.

On the basis of this, I think we are doing a little better job in picking the kind of man who will be adaptable to the responsibilities which he must assume very shortly after he graduates. I think that one of the reasons why the Coast Guard enlisted man has a feeling of confidence and security in his officers when he goes aboard his ship is that he feels his officers are adequately trained, that they have been selected not only for their technical ability but for their leadership capacities.

I have thought as I heard the discussion through the morning that while I am still unconvinced there is any difference between a war neurosis and any other type of psychoneurosis which I have

seen, nevertheless, the precipitating factors are somewhat peculiar here and to a great extent depend upon the officer material which the maritime service can provide to man their ships.

CHAIRMAN BOWMAN: I am going to call next on Dr. William Hoffman, of the Norwegian Public Health Service, who is at present in charge of the 100-bed convalescent home for Norwegian seamen at Chester, Nova Scotia. Perhaps he can tell us a little of his experiences and give us something of value.

DR. WILLIAM HOFFMAN: Thank you, Mr. Chairman!

I should like, first, to express my gratitude for having been invited to attend this meeting. I have been very interested in hearing not only the presentations but also the various viewpoints on these cases.

What I would be able to contribute would be some figures as to the frequency of these cases. The convalescent home at Chester is accepting not only torpedoed crews, or nervous conditions, but all kinds of diseases. It has been at work since June, 1941. I have reviewed the number of cases we had during the year 1942—that is, cases I have mainly seen myself.

During the year 1942, about 25,000 Norwegian crew members visited Halifax. That means 25,000 single trips, all of them having been exposed to some extent, all of them having arrived at Halifax through the danger zone. At the same time, during the same year, 296 men were sighted off Halifax after having been torpedoed. Of these approximately 300 men, only nine were admitted to the convalescent home because of nervousness. The rest of these men, 290, represent on the one side our lack of information, and on the other side they represent those that take care of themselves. That means that they are drifting along ashore for a month or two, and when their money is gone, they finally turn up at the shipping master's office, in the meantime having what perhaps we now should call alcohol nerves.

I would like to digress from these nine cases and explain that among the cases I see in Halifax, I have many coming from other parts of the Western Hemisphere. They are not all coming through Halifax, but the greatest proportion of the 300 did. They are the only statistics I can give as to the frequency because I have not material to show how many have been torpedoed in other parts of the Western Hemisphere.

During the year 1942, I had 60 psychiatric cases at the convalescent home. Half of these cases are not pertinent to our question today, consisting of questionable syndromes and patients with other organic determining factors or major psychoses. In spite of that, I really think some of those major psychoses are reactions to the war situation in a more special sense. Some are due to life-long constitutional make-up. The other half really belong to the group we speak of as having "nerves." Now, happily, just half of this group do not blame the war or war experiences for their nervous condition. That is, more generally maladjusted people—people with dyspepsias, with or without ulcer, and slight alcoholism.

In only half of this group of 30, I mean this group of general maladjusted people, there is no obvious connection with the war situation. There may be one, but it isn't apparently connected with the war situation. And they do not blame the war situation themselves. The main thing, of course, is that you are able at least to indicate with some certainty that these people have not been well before.

This other group of 15 cases, 9 of which came from Halifax, are really war nerves. That does not mean, however, that we can blame a certain incident during the war; nor does it mean that these people have been nervous following an explosion or a certain detonation. Practically all of these 15 blame a certain trip. They tell that they had been attacked during five days or two weeks, and they blame a certain trip. I think that some of them are right so far. I have at least two cases in which, I am sure, as far as I am able to judge, there was no insufficiency before that.

Many of them are simply afraid because they are at war and they have been impressed particularly by a certain trip. Afterwards they think themselves, and they tell us, that it is mainly due to that trip. I think the situation is rather the opposite. They are generally afraid and on that occasion they got a demonstration of what you can get into. But there are some cases, really, where you have a feeling that they have felt entirely well before and after having been attacked during those days they have been torpedoed and got aboard a rescue ship. But after having had this experience, they have developed a more acute picture.

Now, as to the question of the more strict causes of this, I think it should be considered that one of the main symptoms is sleep disturbance. This is not coming on the individual as something from the outside, but the man is starting his sleep disturbance himself by

not going down in his cabin. Many of these people stay on deck and sit around in the dining room, and so on. They are starting to develop unhappy habits and I am not thinking of drinking. There is very little drinking. So down in the cabin they finally pull themselves together. They go down to the cabin and they tell about the peculiar sleep disturbance that I have not heard of before. It may exist in other conditions, too; namely, they do not tell, as many psychoneurotic patients tell, that they have experienced only sleep for a short while, and you discover that they have slept a long while. They tell that they waked up and thought they had been sleeping for hours and when they looked at their watch, they had only been sleeping for a few minues.

Sometimes they say, as we have heard before, that they do not go to sleep really, but they have kind of dreamlike states, where they are imagining all these things that occur.

I have not been able to see any difference between the men who have been aboard tankers and men aboard freighters. In spite of this, I have a special respect for the tankers. But there is a definite difference between the engine and deck men. The engine people are more apt to be nervous than the people on deck. There is a further difference. These people who have to take care of the engine between four and eight are particularly afraid. Of those who are on duty between twelve and four, some of these engineers have told me that they have started being nervous because of the responsibility. The engines are not working as well as during peacetime. That is a result of this slow going in the convoys; a ship able to make twelve or fourteen knots has to go nine knots, and then they have to stop and go and stop and go. Then they start thinking about the fact that they do not have the proper reserve parts, and they start wondering in the cabin when they are off duty whether everything is in order, and they have to go down and see if everything is as it should be.

I have observed one peculiar feature of these pictures I might mention. Some of these boys are particularly afraid of the alarms. It doesn't sound so astonishing if you take it that way, that the alarm means something is wrong; but, on the other hand, this tremendous noise of the alarm seems really to startle them. We have something similar in animal experiments, as you know. Noises are particularly disturbing. I have heard of people who have entirely lost peace of mind, in spite of the fact they were on deck, because of the repeated and tremendous use of alarms every five, ten or fifteen minutes. It excites apprehension.

But, on the whole, I think that the question of prevention is a question of efficiency and it is a question of reduced danger. The thing we can do, perhaps, is to organize the Merchant Marine somewhat better, as Dr. Evang mentioned earlier this morning. I mean it is unfavorable that the Merchant Marine, differing from the armed forces, is so loosely organized. The men are signed off and are more or less left to themselves when they sign up again. In a certain sense, though, they are called upon, but they are going nonetheless to another boat. They are sometimes going with people who are not congenial to them.

What we do is to approach the situation as we do within the armed forces. The Norwegian Seamen's Union (there is only one) has recently done something about that. It has been able to get through a rule that when a Norwegian sailor is signed on and has been torpedoed, after having sailed for a long time, he may have a vacation of a month; but after that time, he is entitled to sign on if there is a ship, or if there is none, then he will at least have the feeling that from that time on, he still belongs to the Merchant Marine. An ideal situation would be if these men were taken by the Merchant Marines of different nations and signed on for the duration. Then, they would get their furloughs when they are left more or less on their own. They shouldn't have the same strict discipline as other men of the armed forces, but they should have the feeling that they belong to the Merchant Marine for the duration.

CHAIRMAN BOWMAN: Thank you, Dr. Hoffman!

This morning we had a considerable discussion about whether we needed a new name for war neuroses or psychoneuroses, and it was suggested that there was a certain stigma carried with this term and that in certain of the cases it was much more a normal state of fatigue than it was something to be christened with a name suggesting an abnormal state.

I believe that Captain Marsteller has a new suggestion that he might like to make at this time. Captain Marsteller of the U. S. Navy Medical Corps!

DR. A. A. MARSTELLER: I think this morning I did not make myself quite plain to Dr. Brill. I am thoroughly in accord that we should make an attempt to teach and indoctrinate our men, but to do this we must start with the families before the men enlist. At this time—that would be during a period of hostilities—we just haven't

the time to do that. So that my feeling is, that inasmuch as many of these reactions are normal reactions, or exaggerations of a norm, we might call them for first admission, say, combat fatigue. Then later, if after study it was determined that these people had actual neuroses, it would be all right to go ahead and give them a diagnosis of the appropriate neurosis.

Another thing I want to mention is in connection with Dr. Baker's talk. I was very glad to hear her bring up the question of alcoholism. Alcohol is always quite a problem to the military services. However, we are in the habit of differentiating the alcoholic who resorts to it as an escape, either from a situation or from his own conflict, and the social alcoholic; say, a healthy Marine outfit that does a good job, meets a situation, handles it, and then goes ashore or goes off and celebrates in a big alcoholic spree. I was very glad to hear how Dr. Baker handled that subject.

CHAIRMAN BOWMAN: There are certain services that are making special efforts at prevention. I believe Dr. John Murray, who is a Major in the Medical Corps in the Army and is doing some work in prevention work in the Air Forces, can tell us of his work.

DR. JOHN M. MURRAY: I thought you might be interested to have a brief summary of the work in the Air Forces in relation to the prevention of mental illness by our attitude toward the early neurotic symptoms.

Now, the Air Forces are so organized that the basic unit in this endeavor is the flight surgeon. First, we need to define the flight surgeon. What is his basic task? His basic task is the maintenance of personnel, particularly in the combat situation. He is attached to a combat unit in charge of the health of his group. The health of his group comprises both the physical health and the mental health. It is amazing to see how much these young doctors, these young flight surgeons, are interested in this special aspect of their work, most of them with no training, especially, in psychiatry. Yet fundamentally they are very good doctors, most of them experienced in practice of some of the specialties, but the great number of them as successful general practitioners.

It is amazing to see the amount of real need which these men have for a psychiatric understanding, realizing what their problems of maintenance in the field are going to be. These men are rather carefully selected and hand-picked before they are sent to the school

to become flight surgeons. They are chosen, of course, for the characteristics that are obvious. First, they must fundamentally have been good doctors and must, of course, have completed work with the Army that is satisfactory in bringing out their integrity, scientific interest, special intellectual abilities, and so forth.

Having been selected on this basis, they are sent to school for a very, very intensive three months' course. This three months' course is divided in two sections. The first six weeks comprise a strenuous course of instruction by, if I may say so, superbly qualified teachers in the medical specialties that these men are going to need in the field. The first specialty that is of great importance is the eye. The suffering from oxygen deprivation, anoxemia as we call it, has a tremendous tendency to bring out night flight diplopia or any latent defect in vision. It seems the eye is the first organ to be affected by this situation, and so these men must have almost perfect ocular equipment.

The flight surgeon, first, has to be trained to be almost a specialist in optics. And he gets that training. Next, of course, is the circulatory apparatus, and they throw a mean cardiology at you there. I know that, because I have just come through it. As a matter of fact, I have just finished my three months' course, and I am well aware of the intensity and extensiveness of the knowledge in cardiology which one has to have in this school.

From there they go to tropical medicine. Tropical medicine is, of course, a vitally important subject for these men to know in order to prevent epidemics of all the various tropical illnesses which they have got to encounter in the regions where they are bound to be serving with their combat units.

Well, we go on to military sanitation and so forth and so forth, the other things that are obvious; but we will end up by coming to psychiatry and there they are given fine courses in psychiatry. Many, many of the young men came to me during the course, or near the end of the course and said, "For God's sake, why didn't they teach us psychiatry like this in medical school! This really makes sense."

I say to them, "Well, psychiatry has advanced since you were in medical school; maybe they threw you something like that in medical school and you weren't so interested as you are now."

"Well," they counter, "I don't know what it is. This certainly makes sense to me and I wish I could get more of it."

I will deviate for a moment, if I may, to tell you an actual experience illustrating the expression of this need that happened a few

weeks ago. Some of the boys with whom I was working at the classification center in Nashville, said, "We want to have a little get-together and go out and have a few beers one evening. Will you go? We want you to come along."

I said, "Yes, I would like to go."

"We have something we want to talk to you about."

I was interested, but they didn't say at the time what they wanted to talk about. They got together. This included a group, I should say, of seven or eight of the young officers. What they wanted to do was to know if I would become sort of the nucleus of a group of those boys who would send me interesting clinical reports of the emotional problems they experienced handling in the field, so I might have them mimeographed and send them around. They said, "We really want to get a fundamental knowledge of what goes on in the nature of psychiatric problems in the field, and this, we think, is one of the best ways we can do it because certainly one of the most fundamental things that we need to be competent flight surgeons is to have a gradually increasing body of knowledge in relation to the emotional problems of the flight surgeons."

Really, whether this will work or not, I don't know. I didn't encourage them too much, because I said, "We may find a better way of doing it." It has been a long time since anything gratified me any more than to see this special interest as it cropped out among these young doctors.

Well, we now have considered the flight surgeon, what he is and the training which he is given. How does he work? He is out in the field among his men; he lives with them. He is part of their daily life. He knows every one of them, knows them by first name, and not only that, but he knows their habits, and he is there to see at any moment when the type of man, the individual, gets depressed, or when the quiet fellow begins to get a little overactive; he notices the fellow who is beginning to drink a little more than he ought to; he notices the fellow showing evidences of sleeplessness and begins to see the factor of emotional problems that are becoming apparent. So that here at this point he should be in a position to undertake adequate treatment, all of which has been very aptly discussed by my colleagues here today in this special situation.

Now, of course, from the beginning of the flight surgeon, we move on into the more elaborate aspects of it. Behind the lines we need psychiatrists; we need rest homes; we need a rather comprehensive setup in order to deal with the problems in the Air Force as wisely

and as aptly as they have been dealt with, for instance, in the Merchant Marine, as brought out here today. This, in a way, is maintenance.

General Grant this morning said we have two important functions. One is selection and the other is maintenance. We will need during the year 1943 approximately 125,000 aviation cadets for training. These cadets must be very carefully selected. Some of them are going to show evidence of tension, neurosis, but that must be qualitatively evaluated, because many lads with tensions may turn out to be what we in the common parlance call "hot pilots". We don't want to reject those, but we need an elaborate psychiatric set-up in this organization to adequately evaluate those boys who are good material for pilots, those boys whose special emotional development will make them good pilots and who won't go to pieces under the conditions of combat flying. We need to follow those boys along the line of their training and see that when they begin to show evidences of the inability to take it, they are, as we say, washed out; and from that point, again, we have a very important psychiatric function to take these wash-outs, to start them over again in a field in the Air Forces where they will be valuable to us and will better fulfill their special abilities. This, in a way, is what we aim to do and is our task of mental hygiene in our branch of the service.

CHAIRMAN BOWMAN: The problem of prevention has been discussed from many angles but more by way of the problem of personality, the problem of emotional stress and strain and of social relationships. There has been very little said as to the physiological factors which may have to do with morale and the prevention of breakdowns, whether drugs, such as benzedrine, may be useful at times, to cite one example. One point that might be mentioned is with regard to diet. We have heard of dietary deficiencies affecting morale and also the lack of salt as affecting the mental state of the individual. Surgeon Commander E. M. Mussen, of the Royal Navy Medical Corps, has done quite a bit of experimental work in this whole problem of salt ond water. I wonder if he would not care to talk to us and see whether there is something in that field that is of significance to our subject under discussion.

DR. E. W. MUSSEN: I don't really know how much you are interested in the matter of fluids and diet in shipwreck conditions. I can certainly bear out the importance of full instructions to seamen,

before such an occurence as shipwreck takes place.

The British Medical Research Council has just produced what I think is quite a useful booklet on this subject. Many of the facts are based on interviews with thousands of survivors, who were questioned as to every aspect of their time in a lifeboat. This was correlated with physiological research into various aspects of minimum food and water requirements.

The most important matter from a physical point of view in a lifeboat is often the water supply. Water rations in our merchant ships' lifeboats give each man of the boat's full company a total of five and one half pints. We found that the best way to use this is to give no water at all in the first twenty-four hours, as at this stage it would promote diuresis and be wasted. The ration recommended from the second day onwards is 18 ounces per man daily. This should be continued till there is 20 ounces left per man, and then reduced to 2 ounces per man daily. This system is based on the fact that man's minimum requirements of water are at least 30 ounces per day. It has been found by experience that 18 ounces of water a day is the smallest amount needed to keep a man fit for the period usual in lifeboat trips. With lesser quantities than 18 ounces daily, rapid and progressive deterioration is bound to occur from the outset

Though large quantities of sea water may cause death, we have shown that limited amounts of sea water may be taken without harm and with possible benefit. This, however, should not exceed one third of the fresh water ration.

In the early days of the war, one of the main food supplies in a lifeboat was a protein containing substance called pemmican. We now realize that such substances raise the blood urea and produce a corresponding diuresis, which is unfortunate when water is in short supply. Accordingly, we now recommend a food ration consisting mainly of fats and carbohydrates.

There are two other matters that were brought up. One is the question of staying on deck, which was mentioned by Dr. Hoffman. I noticed that at the beginning of the war lots of our seamen developed the habit of sleeping on deck instead of going down below. That was the start of their sleeplessness in many cases.

The other thing to be mentioned was the fear of the alarms. I think that was noticed by a lot of people in England. It was the same

with sounds, a sort of reflex, and the sounds of sirens was quite enough to set them off in exactly the same way.

CHAIRMAN BOWMAN: One way of preventing war neurosis has been to build up the morale of the group. There has been some discussion about building up the morale among the merchant seamen. It has been stated that there are certain things that prevent building up morale which are not present in the Coast Guard Service, the Army and the Navy. Among civilians too, there have been attempts to build up morale. There has been a program of education by the New York Academy of Medicine, and I believe Dr. Millet has had charge of that. I wonder if from his experience in this program of working towards civilian morale he feels there is something that he can bring over to this problem of morale among the merchant seamen. Will you tell us about that?

DR. JOHN A. P. MILLET: As I have listened to the discussions, Mr. Chairman, and as very many aspects of the problems have been brought out, I have some feeling that we are veering away at times from the specificity of this whole situation. We have a Merchant Marine. Our Merchant Marine is different in its traditions from the Merchant Marines of other countries. We have had no recognition on the part of the public or the government that our Merchant Marine formed an essential integral part of our national defense in anywhere near the same degree that has been true elsewhere; furthèrmore, as has been brought out, the profession of being a merchant seaman in this country is distinguished by the fact that it is a rather individualistic type of occupation that is sought out by certain persons as a solution to problems of their own, whereas, in Europe, the Merchant Marine offers a well established profession, with traditions inherent in the trade just as in other lines of endeavor.

I think it has become apparent to all of us, as signalized perhaps by this meeting, that the time has come when something very fundamental has to be done in the recognition of the Merchant Marine, both as a part of our future national system, and as a particular field for psychiatric endeavor and contribution.

I have the feeling at this point that we can afford to give some emphasis to what you might call the educational function of psychiatry, and that it would befit us well to study every possibility of using

our knowledge to educate the leaders and the men in this particular field of national defense.

I think that the ship owners and the ship operators need enlightenment. I think those licensed officers who are to have the immediate supervision of the men's welfare should have a psychiatrically oriented section in their course of instruction, which would give them a sense of the particular responsibility they have for playing the role of the kind boss, or, if you like, the kind father, for their men, and to give them insight into the degree of dependence that their men have on their leadership, both for understanding their individual functions on the boat, and for appreciating the fact that they are being properly looked out for, on the sea and land alike.

I think the movement that has been started here for the formation of clubs and rest homes was the first and most essential job for us to have done. The next, perhaps, is to find a means for handling those whose illness requires a longer period of treatment.

The partnership of psychiatry with the union is going to be perhaps one of the most significant things in the whole affair. Necessarily, the union has come to be the source of support on which the men rely for their welfare and for the future programs designed to promote that welfare. I remember Dr. Blain telling me in the early part of his work that the union leaders were very firm in taking a stand: "Now, we are not going to have our men made into guinea pigs," and that when they learned that the interest of the Public Health Service and of psychiatrists was the interest of doctors in taking care of their men and in doing everything they could to keep them well, that was O.K. Now that seems to me to be a very important entering wedge into the future relationship of psychiatry with the union and that a useful collaboration on the basis of better understanding could go a long distance in providing the type of emotional security for the men which they need in this very hazardous service.

CHAIRMAN BOWMAN: Thank you, Dr. Millet! Dr. Millet has suggested that to bring up the morale of the seamen, the proper training of their officers and the teaching of something in the nature of psychiatry to them would be an important step. We have with us Dr. Justin Fuller, of the U. S. Public Health Service, who is Medical Director of the Training Division of the War Shipping Administration. I wonder if he might like to discuss that and other topics.

DR. JUSTIN K. FULLER: Thank you, sir.

As I have listened this morning with extraordinary interest to the various themes that have been woven into this discussion, I think the theme that resounds with the greatest emphasis is the one that attributes marked individuality to the seaman. The seaman is an individualist above everything else. This has been recognized a dozen times today by a dozen different speakers. The seaman who elects to go to sea, who chooses the sea as a career, it has been said, does so for a reason. That reason may have different facets to it, but it fundamentally stems out of the same thing, usually that he is an individualist, that while he is at sea, he finds surcease from something that is unpleasant; and that he finds it better at sea than anywhere else; and it may well be that in this observation we will find a solution to some of the troubles that are characteristic of seamen.

The "old salt," the typical merchant seaman, so many of whom are at sea today, is that kind of an individual. I thought a few weeks back, when the manpower order went into effect, that such individuals would no longer be permitted to choose the branch of service they preferred, but would be apportioned between the services by some sort of rule of thumb, and that the individual would no longer be a free agent in the matter. The Merchant Marine would then be recruited in some such fashion as the Army is recruited—one man in the Army, one man in the Navy, one man in the Marine Corps, one man in the Coast Guard, one man in the Merchant Marine. It hasn't developed in that way, and those men who are planning to go into training now select themselves in much the same fashion that seamen have selected themselves from time immemorial. So we are still confronted by the fact, by the situation, that the men who go into the Merchant Marine choose that profession themselves and still have the individuality which has always characterized seamen. Now that may be good or bad, it may or may not help the therapeutic problem that we have in front of us.

It may be that our problem is one of selecting the neurotic who is best suited, rather than in trying to select men who are free from neuroses.

Colonel Halloran this morning suggested, by inference at least, at least to me, that we might call some of these men, some of these individualists, constitutional psychopaths. The term "constitutional psychopathic inferiority" is a much hackneyed phrase that has for many years been in disfavor in certain psychiatric circles, but to me it has always described a valid entity. Psychopaths make the best

fighters in the world. They have better than average intelligence; they don't profit much by past experience. They are individualists. They are brave. And yet they do have this queer mental condition which makes them a little different, which sets them a little apart from other people, and makes them unpredictable and hence dangerous in certain positions.

If we can find a way to treat the psychopath, so that he will be able to control himself sufficiently to stay within the bounds of safety for the position which he occupies, I feel certain that we would have found the solution to the profitable use of psychopaths and border line neurotics and other "individualists" in the Merchant Marine and other armed services.

The Division of Training, it is no secret, is participating in a plan to staff some 2,000 ships that are expected to be built this year. In all of the eleven units of the Division of Training, there are some 30,000 seamen in training for the Merchant Marine. Those eleven units comprise cadet schools for officers; schools for the training of apprentice seamen, of able seamen for officership, and schools for the training of seamen, cooks, bakers, radio men, hospital corpsmen, engine room men, and so on.

The average length of training of these men is between three and four months, which means that each year we will train somewhere between 80,000 and 100,000 men. We realize very definitely that the time we have in which to train these men is too short to select them as we would like, and to treat as we would like those who have mild psychobiological dysfunctions that we feel can be cured or so much improved that the man will make a good merchant seaman. Some, unfortunately, we have to screen out. But we have been busily working on plans to salvage borderline cases ever since last October, when this problem was placed in the hands of the Public Health Service. We have been training psychobiological teams at each one of these training centers. We have been handicapped to a certain extent by the difficulty of getting good, satisfactory psychiatrists. We prefer to have them on a full-time basis because we think it is a full-time job. We have put into every Training Station, almost without exception, psychologists, and we are adding the psychiatrists as quickly as possible.

Part of the course of training consists of a series of at least half a dozen lectures to each class on various appropriate psychobiological subjects. We try mainly to put between the trainee and the shocking experiences that he is certainly going to be subjected to, a buffer

that will enable him to escape without too serious psychic damage.

Part of the program—not part of those lectures, but an additional medical part of the program—is instruction in first aid and all of its implications. Another part of the medical program is the development of a so-called pharmacist's mate service for the Merchant Marine. The smaller cargo ships of the Merchant Marine have heretofore had nothing at all that in any way resembled the medical service on the smaller vessels of the Navy. In peacetime, a destroyer or an isolated Marine Corps station has experienced pharmacist's mates who are not graduate doctors but who, to all intents and purposes, are very excellent practical doctors. The cargo ship has nothing of the sort and we hope that we can develop enough pharmacist's mates, so-called, to put one on each one of the ships during the war and for a considerable time during the post-war period. We hope that the companies who operate ships will find that there is so much hard cash value in this plan that they will continue to employ the pharmacist's mates we are training and that they will ask us to continue to train those men in peacetime.

Incidentally, a pharmacist's mate on a merchant ship, a non-passenger carrying ship, is not a total commercial loss to the company, because he can act part-time as a supercargo or clerk, thus not necessitating an addition to the number of crewmen. His medical duties consist of looking after ship sanitation, the health of the crew, seeing that the ship is kept clean, helping her through quarantine procedures, and so on. It is generally admitted, I think, by hard-headed business men, shipping men that I have talked to, that a pharmacist's mate under those circumstances will pay his own way.

The merchant seamen of today is by no means the forgotten man that some people think he is. The Victory ship of today is so far distant in its physical attributes for the comfort and benefit of the crew from the ships of a few years ago that there is just simply no comparison. The modern ship in the last few years, and especially the Victory ship, has good sanitation, and refrigeration. The food rarely, if ever, spoils any more. The seaman is, comparatively at least, away and above what he had to endure a few years ago. The seaman of today is no longer the helpless individual that he was even a few months ago.

The training courses at the Division Training Stations include gunnery. Each seaman learns his part in manning a 5-inch rifle, anti-aircraft rifles, and small arms. The gun crews are welded together

by an esprit-de-corps that the old Merchant Marine did not know at all.

Finally, the last point that I wish to make is that the merchant seaman is no longer the casual individual that he once was. The merchant seaman of today on American flag vessels is being educated into the benefits of being in a uniformed service. The standards of physical and mental aptitude that we demand in selecting men for training are now on a par with those for enlistment in the Navy. We feel that the merchant seaman should be as dependable a person as anyone in the world, because he is for longer periods of time isolated with a smaller group of officers than in almost any other military or semi-military occupation. We no longer can select merchant seamen in the careless way that they were once selected. We no longer can condone the orgies that are usually associated with a seaport and a seaman just getting off his ship. And a large part of the reason for that is that the seaman of today will wear a uniform and he must honor that uniform. Thank you!

CHAIRMAN BOWMAN: I believe that Dr. Karl Menninger was telling us this morning about his almost traumatic experiences in flying around overhead trying to get down and not getting here quite in time; but he also had something of a story about some captain that he was going to tell us about, and he will tell us about that now.

DR. KARL MENNINGER: I sometimes think psychiatrists are so preoccupied with why men fail that we are not sufficiently interested in the study of prevention. In addition to what can be learned from those failures in morale, those instances in which circumstances have overwhelmed individuals, we might also consider scientifically, if we can, some of those less familiar instances in which circumstances overwhelm the individual.

In the course of some extracurricular peregrinations, I was invited one evening to a little party at the home of a man who had just published a book. I found the guests to be largely Scandinavian men and their wives who were interested in Scandinavian folk songs; I was interested in that, but I asked the host how he, a sea captain and author, came to be so especially interested in that. "Well," he said, "you see, a good many of my boys are Swedes and Norwegians and these are some of my boys."

"But you are not Scandinavian," I said.

"Oh no," he said, "I am a Scotchman, or I was. I am an American now."

I was rather impressed by that to begin with, and then talking with him, I was struck by some paintings on the wall and I asked him about them, and he said, "Oh, I do those on some of my trips."

I said, "I thought you were an author."

He said, "Oh, I write those books when times are duller."

"Aboard ship?"

"No," he said, "usually in port, because I am too busy aboard ship."

Well, I thought that was enough evidence that that was a successful man and I wanted to know more about him, so I talked with him quite a long time. I even persuaded him to take a Rorschach test. I have known him socially since that time quite well and I won't tell you all about him, but I want to tell you a few things about him.

In the first place, he sails a merchant ship back and forth without a convoy all the time, right now, and I think there have been several accidents but none of them too serious; his ship has never been sunk. But I do know, or I am almost sure, that none of his sailors has been a patient in any of this work yet. I don't know all the reasons why, but I will tell you a few of them.

For one thing, these sailors will not sail with any other captain under any circumstances. They think that he is just simply next to God. How he accomplishes this, it seems to me, might be worth very careful study for more general purposes. I will just give you a few little vignettes. I can't tell you all of it.

He was telling me about one crossing recently in which there was a very severe gale. In fact, it blew one of the sailors overboard, an old-timer; it was that bad. He told me he thought the ship might founder, which is rather rare, and something he had never experienced, but he was pretty worried. The storm was accompanied by frost, ice, sleet and so on. It was so bad he had mid-Western boys who had never been to sea before the present war manning these guns. He sent a sailor out on deck to tell these fellows to abandon their guns, that no submarine or anybody else could survive in weather like that, and for them to get below deck. The sailor attempted to go up and the wind was so strong and the sea so rough that he couldn't get to the men. He didn't tell the captain this.

The next morning, the wind had abated somewhat and the cap-

tain went on deck and he found these boys with their arms locked around the guns lying prone on the deck covered with sleet, their clothes stiff as boards. They were still hanging to the guns. He said, "Well, how did this happen? Are you fellows alive?"

They said, "Yes, sir; we are all right."

He said, "Well, I sent word for you boys to go below last night."

They said, "Well, we didn't get it, but that is all right, sir. We stuck it out."

He said, "Well, you might have frozen to death. You might have been washed overboard. Don't do it again. You should have abandoned your guns"

"Oh no, sir," they said, "you wouldn't have approved of that really."

I don't know all he said, but, at any rate, he said, "Well, go below now anyway and get fixed up."

I mention that as an indication of the kind of discipline he maintains. He said it was absolutely absurd for them to stay there; he wouldn't have reproached them if they had gone down below, and in fact he thought they had gone and he reproached himself because he might have been the cause of their death.

That is one instance.

I said, "Well, did you have any shock of one kind or other?"

"Oh, yes," he said, "sometimes."

I said, "You have no doctor aboard?"

"Oh, no."

"Who treats the men?"

"I do."

"How," I asked.

"Feed them," he said, "just feed them; that's a good treatment for lots of things."

I said, "Your boys get to London and New York; is there a little venereal disease acquired?"

"Oh, yes," he said, "sometimes."

"Well," I said, "you don't discover it until they get back on board. Who treats that?"

He said, "I do."

I said, "You treat both gonorrhea and syphillis?"

"Oh, yes," he said, "I have to; there is nobody else."

So I began to think what a sailor he must be to be able to do everything.

He said, "That is nothing. We all do that. We have to know a lot of things aside from running a ship."

"Well," I said, "who takes over the boat when you sleep?"

He said, "I don't sleep." (Laughter)

I said, "Well, you rest a little?"

"Oh," he said, "four hours a night I do. The mate takes over."

I said, "But you hardly get undressed in four hours and dressed again."

"Why no," he said, "the captain doesn't undress and dress aboard ship; you know that, don't you?"

I said, "Well, some of them do. Maybe you don't."

This may sound a little incredible now, but I believe it is credible.

Now, what are the features of that leadership which so inspire these men, which give them such complete confidence in him that nothing shakes their morale?

I am confident—of course, this is only a hypothesis— that any external events, I mean the ordinary external events which overwhelm men, would leave most of his men untouched, because it seems to me what I missed in some of the discussion of the etiology today is the question of the relation to their captains of the men who were so overwhelmed by these external events. I think this should be stressed because of what several people have said about the character, not just of men who go down to the sea in ships, but of the men in the merchant fleet particularly. My impression, from what has been said here and from one of these sailors who is now a physician, and has been psychoanalyzed, and whom I know well, is that the attachment of many of these men to home figures is relatively less than that of a good many other sailors, and soldiers, and their attachment to one another and to their captains is for that reason all the greater.

There might be, it seems to me, an opportunity to study morale in pure culture on such a ship as I described, run by my friend the brave captain, and it might be exceedingly important to know what the deeper personality structure of such a captain is, because prevention is so much better than cure.

It seems to me that in all our thinking about this problem, we haven't given enough consideration to the nature of the man who, after all, becomes the little Napoleon, the little god, of this 50 or 150 to 250 men with whom he lives so intimately for days and days and days, surrendering all other human bonds excepting those in

this artificial but certainly not unusual human constellation in which morale may be very high—or very low.

This, it seems to me, as Dr. Millet said, is an educational function of psychiatry. Where is there an area of investigation for psychiatry concerning success? Such an area might prove to be a welcome relief after our consistent investigations of failures.

CHAIRMAN BOWMAN: We are interested in experiences in fields related to that of the Merchant Marine, experiences whereby we can learn something about the cause, the prevention, and the treatment of these early war neuroses. I am going to call on Dr. Parsons, who was Commanding Officer of Base Hospital 117 in France during the last World War, to tell us anything he wishes about his experience in the treatment of acute war neuroses and in their prevention that would fit into our program here.

DR. FREDERICK W. PARSONS: Mr. Chairman, Ladies and Gentlemen: I was delighted when I was asked to become a member of the New York Committee of the United Seamen's Service and duly appreciate the honor of being invited to this meeting. I long have had an interest in sailors and ships so I found myself in a congenial atmosphere in the Andrew Furuseth Club. The men of the Merchant Marine are doing war work of a particularly hazardous nature. Some break, but under the direction of the United States Public Health Service physicians (if available, and they cannot have representation in every port) the sick and maimed get excellent care. A few have nervous symptoms and Surgeon General Parran has asked this distinguished group of service and civilian physicians to confer, and if possible to suggest further steps to be taken.

I am asked to speak on the question of prevention. It is difficult to know what to do with these men who travel to distant points and, until they get sick, rarely see a physician. I expect the officers know who is breaking but they are literally at sea, the daily work has to go on, and I judge the officers can do little for threatened nervous breakdowns.

Our Merchant Marine has been prominently in the public eye only since the beginning of the war. Prior thereto it constituted a group of men about which the man in the street knew little and cared less. I expect many of the ship's men felt that way about the men ashore. Now the sailor knows he has friends and we landsmen know more about the deep water men.

The influence of the officers seems important. I was dining out

a few weeks ago and an American naval officer came in, a captain with three of four of his junior officers. I looked at that man and I said, "Mister, I'll go to sea with you or anywhere else."

He had a radiant personality, cool, calm and collected. There was ability written all over him. I think with Dr. Menninger that the men who sail with that man will rarely break down.

Nothing has been said today at all about war nerves among the officers. What happens to them? Do they break down? Where do they go if they develop nerves? Upon whom do they lean if they do have a breakdown? Subsequently in the discussion I shall be very glad if somebody who knows more about the whole question than I do will have something to say about what happens to the officers when their ship is torpedoed. They are exposed to the same hazards which cause breakdowns among the seamen.

I do not take too seriously the psychoneuroses among the seamen. Except for those who have been neurotic for years, the symptoms are not so deeply seated as those we were accustomed to see in the Army. Those whom I have seen at Gladstone and at Oyster Bay delight a physician by their response. As has been said, they have no incentive to hold on to a nervous disorder. They are sailors. They want to go to sea. Ashore they are unhappy, and out of pocket too. When one can do what one wants and get paid for it, why hang on to a psychoneurosis?

CHAIRMAN BOWMAN: We have in this country one organization which is noted for its educational work in the prevention of mental disease, so I am going to call on Dr. George S. Stevenson, of the National Committee for Mental Hygiene, to give us any ideas which he feels pertinent

DR. GEORGE S. STEVENSON: My tendency would be to look for leads among the reactions of persons in ordinary civilian life. We were shown three cases this morning. In all three there was a reaction of embarrassment at speaking before a group of doctors. It wasn't war nerves this time; it was rather nerves brought about by the newness of speaking before a large group. They had not been hardened to this particular situation, hardened in the way that Dr. Rado had suggested the hardening might take place in relation to maritime situations. Now, of course we don't think of their embarrassment as a neurosis, at least not the sort of neurosis that we worry about. The situation is not new. It was described long ago by Longfellow. Miles Standish, a hardened soldier, had to get some-

body else to speak for him because he faced a situation with which he had not had experience.

Dr. Baker has given us some very practical suggestions for strengthening the man for new experience.

In civilian life all persons have gone through a progressive hardening process, not the specific hardening process for the Merchant Marine, but a hardening process that allows them to meet the circumstances of life. The school boys of today are practicing at war play to meet some of the actual war situations they may be having to take seriously in two or three years.

In getting a better understanding of the physiological concommitants I think also of Wingate Todd, who had his medical students learn visceral anatomy on each other by use of the fluoroscope. In that process he discovered that the normal anxieties of the first year medical student were reflected in changes of tone in the stomach. As the hardening process went on and they became sophomores, the stomach became a different organ. He had in this a concrete example of what actually takes place viscerally in the hardening process. By contrast, he occasionally found sophomores with freshmen's stomachs and was able to demonstrate that in those cases the anxiety didn't come from the newness of the situation but from something more akin to a neurosis.

CHAIRMAN BOWMAN: Dr. Meyer, I think as president of the National Committee for Mental Hygiene, you should also discuss a little bit the preventive work for mental health. Give us your view.

DR. ADOLPH MEYER: I have been strongly reminded throughout this day of the man who has probably done most to start, in practice as well as in theory and in spirit, preparing the ground for psychiatry for World War I—I mean Thomas W. Salmon, who was inspired very largely by his experience with the deep sea fishermen, after all a group that also comes very close to those of whom we are speaking at this session. The contact he had with that set of people led him particularly to be concerned with what personal development can do and undo.

We have spoken to such an extent of the inspirational part of this whole field that perhaps we would do well to bring it somewhat into connection with the more theoretical, if you want to call it so, necessities that we have had to meet.

I was very much interested this morning in the fact that three

patients were brought in, that they were allowed to give us the sense of reality of what we had to discuss, an element of demonstration of what kind of facts they offer. Evidently our task in that sort of thing becomes very practical. It demonstrated that we are dealing with what in general is the problem of psychiatry: a call for plain sense in dealing with human problems, helped by clearer and clearer willingness to see and guide the accessible facts.

Psychiatry is very largely that part of medicine, or that part of practice and good sense in dealing with patients, which is concerned with the account of various usual first consequences, but also modes of development and also the yearning for correction in matters brought before us as examples at the start of this meeting.

Our problem in psychiatry is really that of forgetting terms and the quibbling about them, and more that of presentation of data of experiences, a presentation of demands, and passing on to a means of doing justice wherever and howsoever the demands can be effectively reachd.

The regular definition that I usually give of pathology would be more or less in line, i.e., seeing what works; what does not work so well, and why; and, finally, what does not work at all. That is the definition of the perspectives in the concept of pathology and therapy. Evidently we are dealing with something in which also the problem of *morale* has been emphasized. I could not want a better term or better concept for that whole problem than that of "morale" in its best definition. A great deal has been said about it. We might like to look for something that like a chemical, could be bought and handed out. Obviously, it is the balance of security and insecurity, the problem of things that work and things that do not work.

Our purpose is to obtain information, knowing what the goal is for which one heads, whether it is in the Merchant Marine or in any sort of pursuit that has equal hazards, equal dangers.

So this question that we are confronted with is one of loss of security, partly through situation, partly through inadequacy of preparation, lack of hardening process, as Dr. Stevenson mentioned, and then the restoration of the perspective, the conditions under which that sort of restoration is possible, the problem of sleep, the problem of recreation, and a vision of hopes to be active again and for what.

Personally, I have not had any experience in any condensed form with some of the things that many of you actually have had. Some of you have had experience as psychiatrists in the first war. By reason

of various circumstances, I had some experience only in giving some help in training, but I always bring it into connection very largely with that which we have to meet when we see patients not for protracted treatment, where we can leave things more or less just to a question as to whether a patient shall or shall not go into a hospital, but where we have, perhaps in one session or a couple of sessions, to form an idea of how that which the patient brings to us can be demonstrated in terms of a mode of living, terms of a mode of orientation, of adjustment. That is what psychiatry really is doing. It has to determine what belongs to the person's function, what are the hazards from the use and abuse of organs, and remedies of that sort that have come to include rather high-handed procedures to the point of coma and convulsions.

Now there is more and more of an idea of this in the public mind, and we ought not, therefore, to get into that channel which prevails very largely in the English circles, where they make a tremendous distinction between psychosis and psychoneurosis, and evidently very much at the expense of the psychosis. Psychoses are, after all, things that can happen in many forms and are not always what the public thinks them. We have to teach people that when we speak of psychoses, we speak of things that are very close to the status of "the person." There are a good many features involved that we carry as we do a "physical" disease. Those things, evidently, to which all that we call morale applies, that the individual has to meet with promptness of choice also under circumstances of disaster. That is what one also has to get hardened to and intelligent about, and to be able to face and to treat not so much as a matter of horror, but as a matter that requires preparedness of conduct, of vision, of endurance. Those are among the things which, as it were, are largely the upshot of what I mean by morale: the respect for the personal aspects among persons and the respect for health, respect for the coordination of that which is human, one's mental attitude, one's necessity of looking forward, looking backward, and then the means of handling it, waking and asleep.

Sleep means a great deal as a paucity of function. It probably shows in these conditions about as strongly as almost anything that has been mentioned in the symptomatology and in the problem of treatment. It is a most fundamental form of an action of reconcentration, you might call it, and of distraction, followed by reimmersion into the necessities; and the transition states are the ones in which the weeds show as well as the good fruits and the chances

for new gains. I think that has been made very clear in the discussion, together with the handling of the situational uncertainties.

It is a great pleasure to see a particularly concentrated type of vital pursuit and vital emergencies emerge in the text of our discussions, and it is exceedingly interesting to see that at present we still have relatively few opportunities for training and familiarization. What Dr. Hoffman has given us as a picture of his hospital is only to a relatively small extent devoted to a retreat for war victims, but actually offers the nucleus for provisions for the shaping of policies and morale. Most interesting perspectives are brought up in those subjects that Dr. Blain has given us a demonstration of, with material for such a simple program that I would recommend it for all conceptions of psychiatry. There is the story of the patient; learn to translate it into terms in which you can use all the training and sense of your scientific acumen, and then translate it further into life, and therapy, and part of the morale concerning certain lines of occupation, and you will in that way get a good idea of that which you still call psychiatry, but which we do not want again to make a matter of designation of the abhorrent and mere segregation and elimination, but more and more a matter of morale and of health and helpfulness in life.

CHAIRMAN BOWMAN: We have with us from Canada, Lieutenant Wellman, of the Royal Canadian Navy Medical Corps, who is chief psychiatrist of the Navy Yard at Halifax. I am going to ask him if he will say a few words.

DR. MARVIN WELLMAN: Sir and Gentlemen: My experience with this illness has been with fighting men, chiefly Canadian seamen. I am convinced that any personality, if exposed to sufficient trauma, will develop such a reaction. Of the cases seen by myself, 673 to date, I would only have considered 37% as abnormal before the onset of the present illness. Conclusions as to primary instability depends, of course, on the criteria of the observer.

At the Royal Canadian Naval Hospital, Halifax, the importance of early treatment is stressed. The patients are made to realize that this is a way the body has of acting and that it is not something which will take them from the service. The war is still to be fought and they are going back to do their share. Less than 10% are discharged from the service. The remainder are treated and returned to full duty.

I wish to express the regret of the Surgeon Captain at not being

able to attend this meeting as he was detained by other duties in Ottawa.

CHAIRMAN BOWMAN: I am going to ask Dr. Carl Michel, Medical Director of the Coast Guard, if he cares to discuss this.

DR. CARL MICHEL: Mr. President, I have been sitting listening and a great many facts were brought out, but to make the proper recommendation the best way, of course, is to draw on experience. Since we are dealing with seamen, certain facts that have been brought out seem to be applicable to several incidents I have observed with respect to torpedoed seamen. In the Spring, considerable torpedoing was going on down the Florida Coast and I happened to pass by there. One day 400 American and foreign seamen were landed from torpedoed ships. I looked them over; they were all happy, were glad to get ashore and the first thing they were interested in was getting plenty of food. They were all hungry. Well, a while later a ship was torpedoed, a British tanker coming over, and the tugs managed to get hold of her, the torpedo having gone through the engine room. I got out on the tug and got on board the ship. So I observed the behavior of the captain and the crew, just what they were doing. There had been two men on watch and they were totally disintegrated. You couldn't find anything of them. Then I went to speak to the captain, an Englishman, weighing about 250 pounds, and he had a bottle of beer in his hand and he began to talk to me about the event. He said, "The first thing I knew when the ship was torpedoed, I got the men to work," and sure enough, all the men were hard at work cleaning up, working just as hard as ever, and they were cursing roundly. That was about the only reaction I noticed.

Now, all this is applicable to Dr. Menninger's captain. Apparently this master had absolute control of his men and the first thing he thought of was keeping them busy so they couldn't think of anything. Naturally they had found an outlet—they were cursing. But none of them went back to the engine room where the disaster occurred. They were working hard cleaning up the ship. The first thing they wanted to know was when they could get to port and get a cargo so they could go back home. That is about all.

I certainly have enjoyed the meeting. There are so many facts that have been brought out, I think with marked success, that the future prevention of neurosis among seamen should be cleared up in a short time.

CHAIRMAN BOWMAN: Dr. Foster Kennedy, would you care to say something?

DR. FOSTER KENNEDY: Gentlemen, I came away from the last war with the absolute knowledge that the morale, the emotional tone of a regiment, depends more on two officers than on any other one thing —the colonel and the doctor. The colonel and the doctor can set the tone, the emotional tone, of 1000 men. The doctor is the liaison officer of the colonel. He has to know all the men, and as many as possible of them by name. He censors their letters. He must know them in an intimate way that the other officers cannot achieve. He must look after them when they are not in action. If he does his job well, and knows his men and looks after them, they will not break down when trouble comes, if they really trust him.

He must also go on occasion, wherever other combat officers go. He must go over the top with his men. If they respect him, the men will not panic under any situation.

So I suppose it is the same at sea. The captain sets the tune and the doctor plays it; and if these two officers work together and are fighting men themselves, the tone of the men will be sound and men will go back to be fighting men again.

The doctor, I think, has to be told also in his training that his job is a preventive one. He must spot a man going sour. He must detect a man who is sitting apart, whose attitude is one of dejection, who has lost the fire in his face, who has begun to brood. He must pick that fellow up and go and see him, see what is the matter, take him out of line, take him out of work, if necessary, or give him more work. The officer who spoke last had the right idea of it, that nothing takes up excessive adrenalin like work. The doctor has a preventive job in the psychoneuroses on land and at sea. We are told too much, I think, about how to cure and too little about how to prevent. If the doctor is a man himself, the men around him will also be men.

CHAIRMAN BOWMAN: I am going to call next on Dr. Rademacher, of the Public Health Service, who is a psychiatrist, I believe, at Sheepshead Bay Maritime Training School.

DR. EVERETT S. RADEMACHER: Our job as psychiatrists in the training station is, like that of Dr. Felix, more of selecting and picking out of men rather than the actual treatment of shocked seamen.

This morning there was some question as to whether there might be certain differences in the nature of the men volunteering for service as contrasted with those of the Selective Service group. There is perhaps very little difference in many respects. One finds that many men volunteering for Coast Guard or Maritime Service had rather false ideas as to the true nature of these services. Within a few days of their enrollment they discover what they have let themselves in for and the result is a shock to them. This shock appears often in the form of a sustained fear reaction, comparable to the clinical states we are discussing.

One speaker brought out the fact that there were many service men who had difficulty in adjusting to service and whose history tended to show that as little children their play activity was more destructive in nature. I think that we can carry this further and show many traits of adolescent behavior which can be used as an index to success in adjusting to any service.

For example, there are many individuals whom we see after only two or three days on the station. They have thrown out a knee cap or injured a back, etc. Invariably they add that this is the same thing that happened when they wanted to play football or some other sport. With martyred attitude they declaim their ill fortune that these things should happen right at these times. These so-called "football heroes of a day" show a need for further study and as more is discovered about this form of reaction, a better screening takes place.

The more we realize the importance of earlier personality difficulties and neurotic disturbances, the fewer breaks of a "nervous" nature will be in evidence as a result of military service.

CHAIRMAN BOWMAN: At this point, I am going to ask Dr. Overholser if he will take the chair for the next half hour, because Dr. Parran has asked me to go outside.

Dr. Overholser will take over the chair and the meeting will continue until five-thirty. There are one or two people I have asked him to call on and then the meeting will be thrown open to the general discussion.

(Dr. Winfred Overholser assumed the chair.)

CHAIRMAN OVERHOLSER: Dr. Titus Harris, consultant of the Marine Hospital at Galveston, Texas. May we hear from you?

DR. TITUS HARRIS: Dr. Overholser, I don't think that I could

say anything that would contribute to this meeting. I have enjoyed hearing the various discussions very much. Certainly the various discussants have said a lot which will contribute to our information about the prevention of these war nerve conditions.

Since I have received the announcement of this meeting and an invitation to attend, I have been thinking of the possibility of establishing one of the convalescent homes in Galveston, in that it is a rather important Gulf port and also because we have a medical school and the State Psychopathic Hospital there, which would enable us to furnish ample medical personnel—that is, if Dr. Blain thinks that there is a need for one in that part of the country. Dr. Blain has told me that he plans to visit Galveston and investigate this question.

To me the meeting has certainly been a success.

CHAIRMAN OVERHOLSER: I would like to hear from Dr. Macfie Campbell.

DR. C. MACFIE CAMPBELL: Out of twenty-one merchant seamen that have come into the Boston Psychopathic Hospital in the last year thirteen were suffering from alcoholic psychoses. So I was interested to find this forenoon no reference made to alcohol. As Dr. Kubie remarked, the seaman is somewhat of a solitary individual, free from the ordinary social bonds, attaching himself to small groups on board ships, and when in port exposed to a more unfortunate environment than any other group that I know of. I suppose the environment is improving.

With regard to the total situation, the difficulty is how to reach the individual. With the Army you have a very large, highly organized system. In peacetime, if you are dealing with the workingman, you have very large aggregations in industry. If you see factors that might be of importance to the welfare of the individual, you have already an organization where you can introduce beneficial measures; the relation, for instance, of the foreman or of management in general to the industrial worker is often open to modification. The reaction of the average workman with a repetitive task to his situation in one case may be resentment and labor unrest; with a different morale or atmosphere it may not lead to any trouble. But when you take the situation of the merchant seaman, you find he works in very small units; he is an individualist and works in a very small group which may be conducive to acclimatization but also to paranoia. In connection with the Challenger oceanographic survey,

Sir John Murray said that after they had been to sea about six or eight weeks, members of the expedition were barely on speaking terms with each other. When they put in to port all scattered and got new experiences; when they came back to the ship, they were all very good friends again.

So here you have these units, small groups of these individualists, and the captain in a position of very great importance. In trouble, the first thing I believe the deckhand does—on a small ship anyway—is to look to the bridge and see how the lieutenant, or whoever is in charge, reacts. As Dr. Menninger remarks, the captain of the ship is the man who has to deal continually with emergencies. He has even to set a bone if it is broken. He has to give medicine. If the shaft of the propeller goes, he may have to go down and help the engineer straighten things out. In the Merchant Marine as in the senior service they are always fighting, always fighting against the elements and having to make very serious decisions.

I think it very difficult to see how you can introduce preventive measures that can touch the individual seaman through any group influence except through the unions and perhaps such organizations as the Seamen's Institutes.

With regard to the officers, they might get some such insight into human needs as it is possible to give management and foremen in industry. The first medical contact may take place when the man has broken down. I think the most strategical position is held by the Marine Hospital when the seaman goes for a systematic review.

That first contact is of extraordinary importance, I think, because with the right sort of attitude the temporary conditions of the men may be very judiciously and rapidly dealt with. Under different auspices, the seaman may fail to get a wholesome outlook and perspective, and may come to the rest home predisposed to prolonged invalidism. Very close cooperation between the Marine Hospital and the rest home is desirable, as between a rehabilitation center and any other hospital. In the organization of the rest home, perhaps the unions and Seamen's Institutes might have valuable suggestions in relation to the speedy rehabilitation of the seamen.

CHAIRMAN OVERHOLSER: Dr. Rado, may we hear from you?

DR. RADO: Obviously, prevention is a most important aspect of our problems. I should like to call attention to the fact that prevention is possible and necessary in three successive lines, and that

in each of these lines we are facing somewhat different problems. The first line of prevention is to prevent acute reactions from occurring. If this fails and an acute reaction develops under treatment, the second line of prevention is to prevent relapse. This is the true criterion of the efficaciousness of every treatment from the military point of view, and here also from the point of view of service a man is only cured if he is returned to full service, and that implies that he is now considered safe from relapse.

The third line of prevention is to keep a man with an acute condition, whom we can no longer return to full service, from deteriorating further, and from developing an organized fear of combat and war and turning into that classic picture of traumatic neurosis, a man who will be lost not only for the services but also for society.

The task of all of these three lines, therefore, is different. Problem No. 1 has been very ably discussed by Dr. Baker. It is a problem of morale, but we discussed this morning, in addition, a problem of indoctrinating a proper technique as to how the man should resolve both the situation and himself. The problem can be stated in one sentence. The situation touches off the most elementary human emotions—fear and blind rage. If the man spurred by morale permits these emotions to arise and then, spurred by morale, tries to repress them, he is licked. His problem is to prevent these emotions from rising at all.

The technique I am talking about shows that it can be done. A very simple experience is illustrative. We all remember in medical school when we first saw the inside of a dead human being, the reaction of fear, revulsion and disgust. That gradually disappeared and was completely replaced by a technical reaction. You saw only the medical structures, and there was no intrusion of human emotions any more.

Now, the whole problem in combat is to keep your mind and body busy in a technical and rational way. If your body and mind are permitted to be idle, then it is almost inevitable that those emotions which hold sway will begin to turn your mind on this human way of looking at the situation; you begin to develop fantasies such as, "How can I get out?"

It was reported this morning that idleness is a great danger. Now, in the Merchant Marine the situation is particularly difficult. The men who have a gun feel better. They can be busy with the gun. I saw in January of last year a British sailor who went through the "blitz" in Coventry and I was delighted and amazed to hear this

man relate his experience. We had a group for the study of these conditions. He was invited to talk; a simple guy, an ordinary sailor. He said, "The man who keeps busy and the men who are able to take responsibility for others are safe. The men who are kept idle are in a terrible condition."

Now, this is the essence of that whole situation. How can that be solved in the Merchant Marine where there is this inability to shoot back, to do anything? It is a very ticklish problem.

I should like to say a few words, if it is not too late, about the beautiful study of Dr. Menninger. There can be no doubt about it that you can build magnificent morale on attaching yourself in a semi-religious way to a leader. This is a powerful prevention, but a psychological setup with frightful dangers. Did it occur to you to ask what happens if this captain dies? Now I will answer that question. I had the opportunity in Captain Marsteller's hospital in Bethesda to see a Marine major who was second in command under a lieutenant colonel in the Guadalcanal area. This man's mind centered around the problem of what was going to happen to him if the lieutenant colonel died. If it was reported that Japanese snipers were here and there, he would say, "Come boys, let's get them." He went everywhere and over-exposed himself and it drove him into Bethesda Hospital. That may come from such an attachment.

I believe that in addition to organization and discipline, the man must be able to stand on his own feet, and all war experience brings out more and more the increasing significance of this point. These two principles are opposed. Therefore, we can not go very far in that direction.

Now, as to the prevention of relapse and of traumatic neurosis proper, I would just limit myself to one thing. Once there is an emotional, an over-emotional state induced, and the individual tries to suppress those emotions, the minute you permit in his conscious mind the idea to take form, "Let me get away,"—and that idea is certainly forced there by all such things as giving him a diagnosis, telling him that he is sick—you don't do him any good.

Therefore, the point I wish to make here is that I heartily welcome all these measure that have been taken in this organization to eliminate the introduction of ideas that feed the anxiety of the man. I am not afraid of camouflaged psychiatry; we are dealing here with a practical problem and everything that is suitable must be done.

CHAIRMAN OVERHOLSER: Gentlemen, there are about fifteen

minutes left before the scheduled time of closing. There are several men who have not been heard from who I know could add a good deal, if they will. I won't embarrass them by calling on them, but there are fifteen minutes available. We would be glad to hear from any of them.

DR. LESLIE H. FARBER: My experience has been similar to that of Dr. Hoffman, who mentioned the very small percentage of traumatic neurosis at the hospital in Nova Scotia. Since I have been at the Norfolk Marine Hospital I have not seen or heard of a single case among merchant seamen, although I have seen two or three cases from the Coast Guard. Before I came to the hospital, 200 torpedo survivors had been brought in directly from the lifeboats, and I was surprised to learn that none of the medical or surgical men had seen any traumatic neurosis among them. It may be that a few cases were missed for lack of psychiatric training, but I would guess that the incidence, if any, was remarkably low.

At present we have between 50 and 100 merchant seamen there all the time, at least half of whom have been torpedoed at one time or another, and I am amazed at how little psychological disturbance among them can be directly attributed to the war. I think the reason lies not only in the merchant seaman's personality, but also in the special conditions of the maritime service which permit an unusual degree of personal freedom. If a seaman dislikes his captain or his ship, he can transfer to another for the next trip, and he is not forced to accept the first ship that is offered to him. I think this all helps to insulate the merchant seaman from neurotic disaster.

In this connection, I must disagree with Dr. Hoffman's suggestion that each seaman should stay with one crew for the duration. That would be almost fatal for many of the men I have seen. They need that individuality and independence—the rebellion that is a characteristic of their trade and their personality.

DR. FELIX DEUTSCH: I should be immodest if I were to take your time for ten or fifteen minutes to make remarks of my own. But I was impressed by many things that the speakers said. If my memory is faithful, I remember that they were paraphrasing much of the book of Freud on group psychology, and all that has been said here in the last few minutes is written there. The Army and Navy is an artificial group, held together by a relationship of a father and the brothers. This relationship is the basis for as well as the means of preventing

breakdown. So indicated Freud, very carefully as was his wont in this book, which I highly recommend that you read, because it will give a good basis for further thinking.

CHAIRMAN OVERHOLSER: Is there any further discussion?

DR. JOHN A. P. MILLET: I arise to a point of information. Very little has been said about the expected disposition of those cases which have been found unsuited for further service, either because of unexpected relapses or because the nature of their disability on the first attack seemed to prove that they were unlikely to succeed in further service. It seems to me that we have here a tremendous problem in rehabilitation. I am wondering what plans have been made by the Public Health Service to cover this problem, which should be faced along with the rehabilitation of people who are physically injured.

DR. VERNON WILLIAMS: I should like to ask a question, or perhaps make a suggestion, in regard to the treatment in these rest homes of which we heard. According to the memorandum which we have, the individual patient is given forty-five to sixty minutes in which his history and first interview take place. After that, about three ten-minute private interviews a week are given. Now, perhaps I misunderstand, but if such a short time is given the men, it would seem to me that the active psychotherapy doesn't cover enough time. I would doubt that the slap on the back and the brief reassurance that could be given the men in such short interviews would be very telling.

Then, also, in regard to prevention and therapy, it occurs to me that there are three factors that may be of importance. One of them is what Dr. Strecker mentioned this morning—idealism. I am wondering if in dealing with the men in their group talks or individually, the ideal could be stressed more than it is at the present time; that is, if it could be put across to them why they are fighting, perhaps for freedom, if that seems to appeal to the therapist as being the point of view to pursue.

Then also I think a point that Dr. Hall brought up this morning could be emphasized in therapy, the idea of fatalism. We understand from the last war that if a man had the idea that this particular splinter or that particular bomb had his tag on it, well all right, he accepted it. Now, it seems to me that it might be stressed in therapy, let the man's autonomic system jangle and jingle as it will, it will do

no good, and he might as well realize that if his time has come, that is all there is to it.

Also, a third point might be used in therapy. That is the idea of perspective. I have the impression that not only in this sort of problem but also in the neurotic situations which we see in every-day life, the individual's ego, his self-importance, is too marked and he doesn't have perspective. After all, he is just a fairly small atom in a huge universe. It seems to me that an attempt could be made to put across to the men the idea that it doesn't make much difference really whether they live or die; and it doesn't. Of course, they think it does, because their own egos are so important, but I think the idea of relative unimportance could be exemplified in such a way that some of them would accept it and it might be helpful.

Dr. William A. Bellamy: In answer to Dr. Millet's question about rehabilitation we have been very interested in this problem and have investigated the existing facilities and made inquiry concerning the Barden Bill.

The New York State Bureau of Rehabilitation and related agencies will care for a certain number of these cases. The Federal Government may loan money to the State for vocational training, job adjustment and rehabilitation, but no money is provided for maintenance of these men during the period of training.

It is considered best to decentralize the handling of these cases. They may be returned to the state in which they have a legal residence. New York State is permitted to rehabilitate out of state residents upon guarantee of reimbursement from the state in which the man has legal residence.

We have received pledges of help from unexpected sources. For example, the National Society for Crippled Children of the United States of America has offered its facilities to help with this problem. This organization has representatives in foreign countries who can be called upon to visit in foreign ports seamen who need rehabilitation. The morale is greatly improved when an American seaman in a strange land in the midst of strangers can have a representative visit him and explain the facilities for rehabilitation which will be open to him as soon as he returns to this country.

It is important that the ground work for rehabilitation be laid while the patient is still in the hospital. Otherwise, valuable time is lost. An unfortunate case recently came to my attention. A seaman, torpedoed off Iceland in December, 1941, was hospitalized for six

months in Halifax. Due to frostbite and gangrene, both feet were amputated just above the ankle. He was transferred from Halifax to the United States Marine Hospital, Boston, Massachusetts. He left this hospital against medical advice and came to New York City, where he stayed with friends. The case came to my attention in October, 1942, and then only because the friends could not possibly care for the patient any longer.

This patient became depressed and felt there was little use in his going on living. At the Health Center at the United Seamen's Service Club House, I treated this patient for his mental condition, and also arranged for vocational analysis and guidance at the New York State Bureau of Rehabilitation. The result has been very gratifying and the patient is now on his way to recovery.

We hope to prevent the occurrence of such situations by working out a plan of referral of cases for rehabilitation while they are still under treatment in the hospital.

Domiciliary care is still a big problem in these cases. At present there are no Federal or State funds available for this purpose. Many of these men are denied rehabilitation facilities because they have no place to stay. If there are any of you who have any ideas on how we can provide domiciliary care for these men, it would be very helpful.

DR. GRACE BAKER: I would just like to make a point to you again of the value of individualistic nature of the seamen. Dr. Millet has asked about what we can do as alternative plans when we think they are not able to go back to sea. They themselves decide it. From the men with whom I have talked, I have found that any suggestion I had, although they responded to the interest and the feeling that we cared, was not followed. They usually went out then and made their own plans.

One of the things I found particularly was that a man recognizing that he was not yet feeling well enough to go back to sea, usually went into shipbuilding. They made those plans themselves, and on two or three occasions, as I now feel, I too early suggested a plan for them. I mean I had definite jobs they could have done. They certainly appreciated the interest but when I found that they had a plan of their own and certainly most times I thought it was a much better plan.

I feel quite strongly the need to emphasize that the man in going to sea has made some attempt at solving his problem, and I would

hate myself very much to feel that the sign of individualism meant illness. If he has had a problem at home, I think the very fact that he isn't willing to take it may be a very healthy sign. We might feel that he should perhaps stay and fight the thing out. Well, he may not be that well. He may not be well enough to do that but I think it is healthy, if the circumstances are unfavorable, that he doesn't put up with it. I think that that sign of his individualism, that evidence of fighting, indicates a self-reliance in him and I certainly thoroughly agree with Dr. Rado that, although you can see the great sense of security he may get from an officer on whom he relies, it is essential, too, that that be balanced by using all of his own efforts, because he may sometimes find himself alone.

CHAIRMAN OVERHOLSER: This morning Dr. Watters was called on but wasn't in the room at the moment. May we hear from you, Dr. Watters, all the way from New Orleans?

DR. THEODORE A. WATTERS: Mr. Chairman, I appreciate your calling upon me after so many distinguished speakers. A few notes made here and there as the day has gone along are to be given commentary.

I have given thought for a considerable period of time to the need for an overall centralized form of psychological indoctrination on democratic principles for all of our men who go into our various services. There are men here who are far better students of military affairs than I, but I can't help but be reminded of Dr. Mira's statements, and those of medical officers who have come to me from adjacent camps and spoken about the confused thinking that some of their patients have about the reasons for fighting and what they want to accomplish as a result of their fighting. I merely bring this out in view of the fact that numerous speakers have spoken about the ideals of these seamen, and we certainly must serve to build up ideals in them as to why they are fighting and participating in this huge effort that is before us. Their psychological as well as their physiological equipment must be marshalled and well directed.

I regret to see us undermine any of the work that we have done for the past twenty or so odd years in trying to modify the fixed and prejudicial thinking, both lay and medical, as to what nervous disorders actually are. They are nervous disorders, and the public simply has to be educated to accept them for what they are and what they can do. Therefore we must formulate our plans to handle them

as they are, the best way that we can. We must not play ostrich. Rather must we shape lay and medical thinking on different premises and according to more honest and realistic attitudes. What is needed still is more enlightenment by medical workers, and a more courageous, diplomatic, consistent and enterprising plan and policy as to diagnosis, disposition, and management. It is astounding how even today we fall for the magic of thought. Changing the name does not change the thing. As a rule it is useless to put new tags on old things; rather must we create new attitudes.

We all remember at one time that we thought in terms of epilepsy, whereas now we think in terms of the epilepses. At a meeting in New York during the holidays, there was one session about fatigue, and, candidly, one gained a great deal from hearing the various workers bring out all the different kinds of fatigue states that human beings have and under what conditions they are acquired. So it is well that we avoid thinking of fatigue just as one entity, but rather think of it as a constellation of allied sensations and physical and emotional states.

I think it might be well for some of our military minds to draw conclusions from comparative observations and study of our soldiers, who certainly aren't fighting for mercenary gain, and those soldiers who are under duress and fighting as conquered people. We might get some leads as to the incidence of breakdown among these respective groups as well as other interesting psychological data.

I am sorry that Dr. Karl Menninger did not make remarks about the selection on the part of the seamen of their particular work, and the psychological motivation and structure behind such choice of service. He is competent to give us a nice discussion on this matter. Perhaps he will later.

I personally would be very happy to receive the handbook which is to be given seamen, and about which Dr. Blain has spoken. It is worth while for us to read it for our own enlightenment and possibly with the hope of making suggestions.

The whole pattern of helping these seamen is what one might call a mellow attitude towards their nervous disorders, which as a frame of reference might be applied to other services. We would do well to watch this program because it certainly provides a more flexible way of dealing with these illnesses that we have had in the past.

I can say from my personal experience derived from helping some men of the armed services, in the Army and Navy, while they were on furlough, that they aren't so willing to completely expose

themselves and their problems within the setting of discipline; whereas, when they have access to a civilian doctor, they often tell about problems that were not detected in the services.

Again, Mr. Chairman, I thank you very much for the opportunity of making these remarks.

CHAIRMAN OVERHOLSER: Dr. Musser, it would be a joy to us if we might hear a word from you, sir, in closing the discussion.

DR. JOHN H. MUSSER: I feel very much as if I were a mouse in the lion's den, not being a psychiatrist and not being in the uniformed services.

I do have one or two impressions from a somatic point of view that I might bring out. I must say I do not like the term "war nerves." I think that that has certain implications which are not of the best. Some of you may remember that some eighty years ago Dr. DaCosta coined the term "soldier's heart," and that term lasted up to World War I, when the condition was called neurocirculatory asthenia. I think it was an excellent term. It certainly did not imply at all that the soldier was, as the term "nervous" does, somebody who was unstable and who might be a neurotic or whatnot.

One other thought I had about all you psychiatrists in general was that you talk only about the psychiatric treatment of these people. Well, a lot of you know that they often do not have fears expressed as such and do not have headaches and do not have bursting noises in their ears and all that kind of thing, but they do have somatic expressions which are very definite.

As to the heart, which I mentioned a second ago, Dr. DaCosta expressed himself very well indeed with reference to soldiers, as well, I imagine, as to seamen. The term neuro-circulatory asthenia implies that they have marked asthenia, that they have tachycardia, that they have a very unstable blood pressure, that they complain of marked shortness of breath, and that their dyspnea is so great they can not do anything physical. I think that consideration of the somatic expressions really should have some thought in your mind.

Incidently, in the plan that Dr. Blain has promulgated for the treatment of these men, I do not see any very great accentuation being made on physical exercise, which I think for this type of neurosis, a particular type of neurosis if you wish to call it that, is probably as satisfactory a form of treatment as any. I remember in our hospital in the last war we had some forty of these young soldiers and

our psychiatrist worked with them. I must confess I think that the best results were attained by the man who had charge of physical education at the University of Pennsylvania. He had setting up exercises for these men and graded their exercise. Then he took them out for a hike in the afternoon, some of them for only half a mile and some for a mile and some for three miles. But, of course, he took the elementary cases and the psychiatrist had the difficult problems.

I think the whole discussion today really has been extremely interesting and I am very glad indeed to have had the opportunity of hearing so many distinguished psychiatrists.

CHAIRMAN OVERHOLSER: Thank you, Dr. Musser!

DR. HUGO MELLA: Our organization, the United States Veteran's Administration, determined some years ago that the care of functional nervous disorders is an out-patient problem and that as a rule hospitalization, except for diagnosis or treatment of complicating disorders, is not wise. The re-socialization centers established for seamen suffering from neurosis appear to be the ideal.

There are still approximately 36,000 veterans of World War I drawing monetary benefits for disabilities due to functional nervous disorders—this is, twenty-four years after the war. Therefore, no efforts to alleviate the acute neurosis occuring at this time should be neglected.

CHAIRMAN OVERHOLSER: Thank you! Dr. Mella.

DR. VIOLA W. BERNARD: It would be merely repetitious to further discuss the principles of prevention and treatment so fully covered by other speakers. I will confine comment therefore to emphasizing the extraordinary opportunities for clinical research and mental hygiene education this program offers, in addition to its immediate function of providing essential services to seamen.

Particularly favorable experimental conditions prevail for the much-needed investigations of the whole group of psycho-physiological reactions to traumatic experiences, which include the traumatic neuroses, states of "combat fatigue", and other psychosomatic disorders. Thus, the number of variables and unknowns is reduced because the merchant seamen present a relatively homogeneous group in terms of certain basic personality and socio-economic factors. (This will not apply in the same way to the newly recruited trainees,

of course.) There is a degree of uniformity in the stresses to which the men are exposed; the nature of the traumatic event, as well as conditions immediately preceding and following it, can generally be known; subsequent reactions in a controlled environment can be observed.

The program also provides a valuable laboratory for testing and perfecting methods of combined treatment through the coordination of several different professional groups. The clinical team-approach, as known for instance in the child guidance field, and proving so successful in some Army mental hygiene units, is being worked out in its own form for the seamen. Here we find that the psychiatric objective of promoting, maintaining and restoring a sense of security is furthered by the integrated use of other contributing clinical and non-clinical resources. There is much to be learned and developed along these lines.

As regards the problem of psychiatric stigma, I believe we should pursue a two-fold course: in dealing with very large numbers of patients who need rapid first-aid methods, the emergency doubtless warrants concessions to their dread of the "nut doctor" by some camouflaging of psychiatry. Men who would otherwise refuse treatment may thereby obtain the help they need. But by the same token, namely, a widespread emergency, we have a propitious opportunity to make great gains in our long-term mental hygiene task of educating the stigma out of the popular attitude. It would seem tragic to forego this chance towards legitimizing emotional disorders by virtue of their universality and publicly acknowledged presence in time of war.

CHAIRMAN OVERHOLSER: Well, if time permitted, we should have hoped to hear from a number of others, Dr. Glueck and Dr. Sullivan and Dr. Kimberly and Dr. Malamud. We are a little over our time already.

DR. HOWARD W. POTTER (Read by Dr. Blain in Dr. Potter's absence): Modern warfare imposes extraordinary stresses and strains on the human organism which sometimes overtax the adaptive capacity of the total personality. The psychological and physiological factors responsible for the breakdown of the total psychobiological economy resulting in a widespread psychosomatic disorganization still require considerable definition. The better we understand the basic pathological disturbances of the body metabolism, the breakdown of hormonal inter-relationships and the

disorganization of the psychological structure, the better the position in which we shall be to establish effective preventive measures and a rational system of therapy.

The medical department of the War Shipping Administration (R.M.O.) has gotten off to an excellent start, but it must go further in order to meet its fullest responsibilities and obligations to the thousands of those men who will develop traumatic neuroses of war in this world wide conflict. Neither the Medical Department nor its sponsoring agencies can afford to neglect the unusually favorable opportunities for medical research in this special field of military medicine.

CHAIRMAN OVERHOLSER: We will reconvene at six.

The conference adjourned at 5:40 p.m., Eastern War Time.

CONCLUSION

BANQUET SESSION

of the

Conference on Traumatic War Neuroses in Merchant Seamen

CONCLUSION

The banquet session of the Conference on Traumatic War Neuroses in Merchant Seamen was held in the New York Academy of Medicine, New York, N. Y., at 8:15 p.m., Eastern War Time, Surgeon General Thomas Parran, United States Public Health Service, acting as toastmaster.

TOASTMASTER PARRAN: Ladies and Gentlemen:

It was two years ago that I landed in Great Britain. One of my first experiences after I landed there was to have a modest meal in the family of a working man, a laborer in Bristol. Before we sat down to eat, a blessing was asked and the blessing was this: "For this food that we are about to eat, we thank Thee, dear Lord, and the British fleet."

And the food they were eating, even then, was no more than we have discarded from this bounteous table this evening. I recall that because of the subject of our discussions today. Perhaps there are American airmen and soldiers in far parts of the world who are much more concerned about the problem that we are discussing today that we are here in the United States. I can visualize some of our boys in far parts, in North Africa or the Southwest Pacific, who may be saying, "For this crate, that we hope to fly, we thank Thee, dear Lord, and that sailor guy." (Applause)

We have been talking today, and shall continue our discussions this evening, about that sailor guy,—the unsung heroes in the battle of the supply lines. The speakers this evening will continue and summarize the rather technical discussions which we have had today.

Before introducing them, however, I can't refrain from trespassing for a few minutes upon their time to think out loud with you my own reactions as I sat here today and this evening and add to that a comment which one of our guests made to me. All of our strategy today, all of our tactics, have been of a defensive character. How can we prevent a loss from combat fatigue? How can we add to the total efficiency of that sailor guy?

And then all of a sudden, one of our guests here today—I shan't embarrass him by mentioning his name—said to me, Dr. Parran, I think psychiatry is coming into its own. This meeting is a first example, but, said he, don't you think that when this war is over, it will be the psychiatrist who will have the great job to do? Don't you think that our task, the task of psychiatry in America, is the mental regeneration of Europe?

Think with me, if you will, what a great projection it is from our discussions of defensive tactics and strategy today to the concept which this eminent man holds—the psychological regeneration of the enemy countries. I had not thought in those terms. I have been concerned with the control of epidemics, the prevention of starvation, the alleviation of the worst of the famines with which we shall be confronted. I am sure that all of us have realized that as we reoccupy one area after another, we are likely to find a scorched earth. Hunger and hatreds will be the major problems. In very truth, a new civilization will need to be built upon this scorched earth. Then we shall need another type of expeditionary force, a force in which American medicine necessarily will play the most important part.

Today the remark of our colleague lifted my sights far beyond the terms in which I had been thinking. I had been thinking in terms of typhus epidemics and the lack of medicines and hospital beds and nurses and doctors and community organization and water supplies and all of the other physical things. But you, this group of eminent psychiatrists, should you ponder the statement of one of your colleagues as to the future mission of psychiatry in rebuilding the world.

Before introducing the speakers of the evening, I should like to welcome here a number of workers on the staff of Dr. Blain and his colleagues. I was inquiring as to who were these attractive ladies who had joined us for dinner. Without introducing them individually, I can only say that we welcome their presence here this evening, because we have been hearing today about the fine work which they are doing.

Moreover, I should like to present to you another one of our guests. We had hoped to have two. We had hoped to have the lady who had donated the beautiful home at Oyster Bay—Mrs. Kermit Roosevelt. Unfortunately, she has not been able to get here on account of the weather. But I should like to present to you Mrs. C. S. Cutting, of Gladstone, New Jersey, who has contributed a very splendid home, one of those that we have been talking about today. Mrs. Cutting, won't you stand?

When it comes to raising money, one not only needs a benefactress like Mrs. Cutting but also someone who is able to go out and raise some cash. The United Seamen's Service, Inc., has been very fortunate in the person whom it has selected to raise money with which to enter many sectors of this job which the government has not been prepared to do. I should like to introduce this gentleman who has had a large experience here in The Greater New York Fund and who is now the National Executive Director of the United Seamen's Service—Mr. Douglas Falconer!

MR. DOUGLAS FALCONER: Mr. Chairman, Ladies and Gentlemen: There are, I am sure you will all agree, two broad approaches to nervous disorders. There is the approach to the fully developed disorder, which falls squarely within the domain of modern psychiatry. And then there is what we might call the preventive approach—the attempt to keep disorders from developing. Some day, let us hope, all medicine, psychic and somatic, will be preventive. But that day is not yet here, unfortunately.

The United Seamen's Service is organized so as to take into its purview these two approaches. Our Medical Division, operated in collaboration with the War Shipping Administration, addresses itself to the task of dealing with developed nervous disorders, most of which are transitory in character. More severe cases are referred to appropriate institutions. We do not attempt to cope with them.

I leave it to Dr. Blain and his associates to tell you about their work, which is being observed with so much interest by medical specialists of the various armed services. I think it is very gratifying to learn that no other war-related agency has preceded us in adapting this same technique of dealing in small numbers with sufferers from traumatic war neuroses.

But, the Medical Division apart, all our work in other directions might correctly be regarded as prevention of psychic and moral disorganization among seamen. This, indeed, is what all morale-building work really boils down to: the prevention of psychic breakdown.

I have met many of our seamen. They live, these days, under terrific tension. Life on the sea even in normal times is onerous enough. But under the circumstances in which these men now function it is sometimes incredible that any of them should keep their mental stability as they do and ship out again and again as they do.

I have talked with a good many of these men who have been on the Murmansk run, men who have been torpedoed repeatedly. They come back to shore shaken. What we and others are able to do for them is welcome. But they want, nevertheless, to ship out again right away. Their fortitude and vitality are amazing.

In order to meet their wartime needs, we have elected to do various things: First, to establish for those who have been torpedoed or who have otherwise suffered shock, convalescent centers where they can be given care and rest and treatment. We already have five of these established.

The second thing we try to provide is overnight accommodations in domestic and foreign ports where there is no other place for seamen to go. We have opened the Imperial Hotel in Glasgow and the Royal Yacht Club in Gourock, Scotland. A hotel in Cardiff is to be opened soon, to be followed by one in Liverpool, and others in Capetown, Honolulu, Trinidad, Durban and various other distant ports. In all these places, as well as in many here at home, we provide overnight accommodations, food, and medical and social service.

Now, these programs, as I say, are unfolding. Attached to each one of them, however, is one part of the service that I want to dwell upon at considerable length. We call it Personal Service, but it is better known as social service. The terms social service and social work are not acceptable to seamen and the term personal service is. We have assembled, therefore, a group of highly skilled social workers who are rendering this "personal service" which is not unrelated

to the work you are particularly interested in.

Working along the avenue of "personal service" we find many opportunities to release tensions and to relieve anxieties, some of them in very simple but helpful ways.

For instance, a licensed seaman who had followed the sea some twelve years came to us recently very deeply worried. He had suffered chronically from a sore throat, had difficulty with his speech and pressure on the larynx, and was afraid to go to a doctor. He feared he had cancer. The problem there, of course, was to persuade him to consult a doctor. It was, manifestly, a job that called for certain skills in reassuring and persuading him. When he was examined a non-malignant growth was found. It was treated successfully. He is now back at sea, and just before he went he said he would enjoy the best Christmas at sea he had had in many a year.

There was another seaman who feared he was going deaf. We helped him purchase an acousticon which he paid for in installments. He is now at sea, relaxed, relieved, his worry gone.

There was yet another seaman, who had been torpedoed twice, bombed and machine-gunned. He also swam through the shark infested waters. Upon his return to the United States he became attached to a girl in San Francisco and gave her a good deal of his money. Before leaving for New York to ship out again, he found she was venereally infected. As he arrived in New York he felt confused, upset, alone, worried. He came to us and offered us $10 just to listen to him. He wanted to talk to somebody. Well, we listened to him—without charge of course—and got the girl under treatment in San Francisco. He shipped out to sea again, relieved and reassured, able to discharge his duties.

There was also a seaman who had himself become infected abroad and had been cured. Upon return home, his wife said she didn't believe the cure part. Here was a family conflict in the making. But we were able to get both of these people examined and relieved of their anxiety.

Still another seaman came to us not long ago, very much worried because he said the police were after him. With his permission we consulted both the local police and the FBI. There were no charges against him, nobody was looking for him, and the man at once relaxed.

One seaman arrived home following torpedoing, knowing that his wife in Queens had given birth to their first child. This poor fellow was just off the dock and he sat there weeping, worried, afraid to go

home. He feared something terrible had happened to his wife. We located and brought her down to meet him. They embraced and he felt better.

Just one more incident that happened recently, concerning a man who had landed here in this rather hysterical condition that many of these men fall victim to. This man had immediately gone on a spree, gotten himself pretty drunk, and wound up in bed babbling that he wanted to talk to Mommy. Mommy lived in Virginia and she had moved. He couldn't remember the name of the town she lived in. And here he was in this terrible state of nervousness, couldn't relax until he talked over the phone to Mommy. Well, one of our social workers went to the Public Library and got a guide that gave the names of all the towns in Virgina. We proceeded to read these names to him. Fiinally, we got to the name that registered in his mind. So we located Mommy and he talked to her over the phone. He relaxed at once.

These are perhaps simple little illustrations of the sorts of worries that these men have. We, for our part, are trying to provide them with somebody who will be sympathetic and friendly and will let them tell about these things before they enlarge in brooding to the point where we would have to give the men more intensive and long-continued treatment. Our efforts may, we hope, obviate some repair work of the psychiatrists.

These seamen, I think we have learned today, are people. Unfortunately, a great many persons have not thought that seamen were people, but that they were something different, a group set aside, not first-class citizens. Unfortunately, too, many of the seamen have had that same attitude towards themselves and have felt that they should stay down on the waterfront when they landed, that they shouldn't mix with other people in the community.

We are trying to change that. We are trying to bring the men back into the community and to give them that sense of belonging which should be part of the feeling of all citizens.

This is the general background of the work of the United Seamen's Service into which your work fits. We started out four months ago. There were no answers in the back of the book. We are experimenting. We are learning. We hope very much that you psychiatrists will teach us some of the answers. We are very grateful to you for having given this time, and we are looking forward to studying in print your discussion.

I should now like to tell you in somewhat great, but brief, detail about United Seamen's Service.

United Seamen's Service was formed in September, 1942, as a private non-profit organization at the instance of the War Shipping Administration, with Admiral Emory S. Land, War Shipping Administrator, as chairman of its board, Henry J. Kaiser as president, and myself as national executive director. Funds for its operation have been forthcoming in the form of donations by the shipping and shipbuilding industry, the maritime labor unions, and the general public. Now, however, United Seamen's Service is a participant in the National War Fund.

The purpose of United Seamen's Service is to sustain the health and morale of officers and men of the American Merchant Marine. This objective is sought (1) by operating port medical offices and convalescent centers in close cooperation with the War Shipping Administration; (2) operating abroad residential clubs and health and repatriation facilities for merchant seamen; (3) providing residential and recreational clubs in the leading port areas of the United States; (4) making available to merchant seamen entertainment as well as recreation, skilled help with personal problems, recreation kits, health literature, survivors' kits, emergency clothing, emergency assistance of all kinds, etc. Within the framework of its extensive and growing facilities, United Seamen's Service offers merchant seamen a wide variety of special services designed to ease their minds of many burdens.

In conjunction with the War Shipping Administration, the United Seamen's Service maintains seven port medical offices in the United States; the number is to be increased. With the War Shipping Administration, it also maintains five convalescent centers for men just discharged from hospitals, men suffering from "war nerves," and men gripped by various types of exhaustion and fatigue. In the United Kingdom, USS-WSA maintain medical facilities for merchant seamen in Scotland and Devonshire. USS-WSA is soon to open a vocational re-training project for seamen injured by enemy action and unable to return to sea. The project will be housed in the headquarters of the Medical Division at 107 Washington Street, New York City.

Residential clubs abroad will soon be located in the following places: Glasgow, Gourock (Scotland), Cardiff, Liverpool, Durban (Union of South Africa) and Oran, Casablanca and Algiers (North

Africa). Services are also being established in Honolulu, Hawaiian Islands; Noumea, New Caledonia; Port of Spain, Trinidad; Paramaribo, Dutch Guiana; San Juan, Puerto Rico; Capetown, Union of South Africa; Tunis and Bizerte, North Africa and Basra, Iraq. Plans are in progress for establishing services in Cairo, Bandar Abu Shehr, (Iran), Bombay, and in all areas into which our armed forces penetrate in Europe and Asia.

Residential clubs in the United States are in operation or will soon be, in New York City, Baltimore, Norfolk, Wilmington, (N.C.), Charleston (S. C.), Mobile, New Orleans, Galveston, Port Arthur (Tex.), Houston, San Pedro, Wilmington (Cal.), San Francisco, Seattle and Portland (Ore.). Recreation clubs are operated as separate entities in New York City; Stapleton, Staten Island; Philadelphia and Seattle.

Recreation and entertainment are offered at all the United Seamen's Service centers. War Shipping Administration workers and United Seamen's Service personal service staff members regularly meet all repatriated survivors of enemy action. Daily they investigate problems brought to them by individual seamen and work out solutions.

"War nerves" is the special province of the Medical Division jointly operated by the United Seamen's Service and the War Shipping Administration, financed in major part since July 1, 1943, by the United Seamen's Service.

The United Seamen's Service aims to help in dealing with all disabilities of seamen. But the major part of its program is preventive. By providing clean, healthful lodgings at prices seamen can afford and by trying to do away with annoyances that might hinder the merchant seaman in the performance of his essential war-time task, the United Seamen's Service makes a significant contribution to the war effort.

TOASTMASTER PARRAN: Thank you, Mr. Falconer!

It would be presumptuous for me to introduce our next speaker to an audience such as this. All I can say is that I am very happy to present to this audience our next speaker, Professor of Psychiatry at the University of Pennsylvania, among many other titles I might ascribe to him, a man whom all of you know very well—Dr. Edward A. Strecker!

DR. EDWARD A. STRECKER: Ladies and General Parran and

guests: I know you wish, as I wish, that I had both the words and the wit to express our very sincere admiration and appreciation of this very splendid thing that Surgeon General Parran has done today. Perhaps it will not be too much to say that it will prove to be somewhat epoch-making in both the history of psychiatry and in the history of the Merchant Marine. I should like, too, to express our appreciation to the Macy Foundation and to Dr. Fremont-Smith for having made this meeting possible.

Then, too, I wish I had the words to express the warmth of feeling that I think we all felt at this opportunity to meet with representatives of our Allies, the psychiatric representatives of Great Britain and Norway and Canada. Happily, the subject of the meeting expressed one of our closest bonds with our Allies, a bond which has been signed and sealed and is being made good to the best of our ability, the bond providing for the delivery of men and the machines and munitions of war and of food, so that they, our Allies, can fight for us and with us, and so that we can fight with them and for them.

I am to give a summary of this conference. It is a rather large order. I take it that one of my functions would be to re-live with you, as it were, the emotional experience of this meeting so that you do not depart from here with too many repressions and with too much unexpended aggressiveness.

One thing seems to be clear to me after participating in this meeting all day and that is that, contrary to general opinion, psychiatrists are very practical fellows, not at all visionary. Perhaps they are as practical as was the psychiatrist in this story which is supposed to have happened in Macy's store.

A little boy was taken by his mother to select a Christmas present for himself. His attention and heart's desire fixed on just one thing, a rocking horse which happened to be the display sample that was not for sale. He mounted the horse and in spite of entreaty and threat and everything else, he refused to be satisfied with anything but that particular sample horse that was not for sale, even though he was told he could have one just like it.

Well, it produced a kind of crisis in the affairs of the store. The saleslady failed to resolve the crisis. The floor walker and the manager both failed. The kid still clung to the sample horse, vowing that he woud have that horse and no other, no matter what might happen. Finally, the manager of the store said, "We have a store psychiatrist.

Send for him. He will settle this very easily."

Thereupon they sent for the psychiatrist and stated the problem and he said, "Oh, very simple indeed."

He whispered a few words into the youngster's ear. At once the boy stopped his crying and threatening and sulking and climbed down from the horse and said, "I'll be perfectly satisfied with one of the other horses like this one," and that was the end of it. But it made his mother curious, indeed, so on the way home she said, "Johnny, what did the nice doctor say to you that made you behave like such a nice boy all of a sudden."

"Oh, I don't want to tell you, Mom."

She kept at him and finally got the answer. "Well," he said, "Mom, he said to me, 'You damned brat, if you don't get off that horse, I'll cut off your ears.' "

So you see psychiatrists may be very practical indeed.

Well, now, more seriously as you recall the happenings of this very fine day, it seems to me that the keynote of the meeting was set by Surgeon Blain who showed us some of the men, some of the patients, who still had some of the wounds produced by our enemy and by the sea. And more than that, we were able to see how rapidly and effectively those wounds were being repaired by the psychiatric service of the Merchant Marine.

Then following that, as you know, the discussion rather naturally subidivided itself into three phases, the etiology and pathology of these difficulties, the treatment, and the prevention. You know how very ably and indeed in what masterly fashion those discussions were conducted by Drs. Bond, Ruggles, and Bowman. I can't, of course, give you a verbatim account of the day's proceedings. I will try to draw, in very crude outline, the pictures that were outlined as each participant in the discussion wielded the mental brush of his knowledge and experience so that finally a rather complete picture emerged.

In the discussion of the etiology and pathology, it appears to be a fact that the merchant mariner is a seaman because he likes the sea. He feels more secure, if you will forgive a pun, when he is at sea. He feels less secure on terra firma. Furthermore, in a way, not without many exceptions, I am sure, he has less close marital and social bonds than those who prefer the habitat of the land. Therefore, since this is true, he is much more apt to establish a closer and more intimate relationship with his shipmates and with his officers. They are his family and the ship is his house. He prefers to have

it on the sea rather than on the land.

Another factor that seemed to be important in etiology was that the merchant seaman has no weapons with which to fight back and that, furthermore, attack comes as a surprise. So picture yourself suddenly confronted with a death-dealing surprise attack upon yourself and your house and without the wherewithal to retaliate. That perhaps describes an important element of etiology.

We are told, too, that as far as selection goes, as to men who were the better equipped to go down to the sea as merchant mariners, those who had any tendency to any epileptoid attacks, those who were stammerers, those who had shown repeated maladaptations and those who succumbed easily to the rebuffs of life, physical and psychic, made poor material.

Then, in various ways, all of them effective, the underlying mechanism and pathology was outlined. Perhaps I could present briefly what might be considered a basic formula which got to be known, under the able leadership of Thomas Salmon, as "the AEF idea" of these war situations. It pictured on the one hand the operation of that strongest and most dominant instinct, the instinct of self-preservation, which leads a man, unless he is very grossly feebleminded, to preserve and guard his life and as the other limb of the conflict, a group of things, thoughts and motivations which might be summed up as "soldierly ideals," ideas of discipline and training and honor and courage and purpose, desires to acquit one's self favorably and certainly not to disgrace one's self. So that we have here the two limbs of an apparently irreconcilable conflict because a man cannot be a good soldier or a good sailor or a good merchant seaman without exposing his life to danger.

Then when a third element was added, probably the least important in many ways, the precipitating circumstance—which in the soldier might be being bowled over by the concussion of a shell and in a merchant seaman it is usually much more serious,—being torpedoed, exposed in the cold and rough sea, deprived of food and water, etc. Here, often, is the extra straw which breaks the emotional back, and then, there is the pathological solution of "combat fatigue."

Now, you can go much deeper and, of course, very rightly, but from the standpoint of what is the important thing for getting your patient well, perhaps I have stated a good working and workable basis.

We discussed also the very hypothetical question of the threshold

at which men break. It has to be very hypothetical. Every individual has a breaking point in his psychic mechanism, as every individual has a breaking point in his cardiovascular system or any other part of his body or organism. In the Merchant Marine, it seems to take a very heavy load indeed to reach that breaking point. So I think, as Dr. Blain very rightly said, we are dealing here in many instances with men having perfectly normal resistance in whom the breaking or saturation point had been reached because of undue hardship and terror and danger to which they had been exposed.

We heard, too, of something we knew before: that fear is a saving and protective thing; that men need to be taught not to be afraid of being afraid, but rather need to be taught methods of controlling the perfectly natural reactions to fear. And we discussed treatment in its various phases, the immediate treatment and the subsequent treatment.

Perhaps here I should like to spend a minute and say that the Merchant Marine is very gravely handicapped because certainly the time for golden therapy is immediately after the occurrence of the "combat fatigue." Then, as we used to say in the A.E.F., the symptoms are still warm and in the making. Of course, the Merchant Marine can't have a psychiatrist on every freighter, but I suggest that this is one of the problems to which increasingly better answers must be found. Perhaps, training some men, not psychiatrists, who can render that important first aid at that golden time for therapy, might be feasible. Even a chance unwise remark at the time the sailor is emerging from his befogging of consciousness may do a great deal of damage: "If it had been a little closer, you would have been dead."

I remember very well years ago at the outpatient department of a hospital seeing an enormously powerful and beautiful muscular specimen of manhood, a Negro, brought in. He had been in a little exchange of pleasantries with razors, and he had a small laceration of his back which wasn't very deep. He was taking it all in his stride, until an intern said, "If that had been a half inch nearer the midline, you would be paralyzed."

Well, I followed the case, through curiosity. Ten days later the big negro came back crawling in on all fours; he was "paralyzed." So that the unwise suggestion made at a very critical time may do a very great amount of harm.

Among other treatment considerations, the importance of giving the seaman an opportunity to unload his accumulated pathological material so that his psyche may be desensitized, so that he can "work

out" with appropriate emotional reaction the thing he has been through, was emphasized. The necessity of providing him with a kind of insight was stressed. It was said, too, very rightly, that one must not forget that there is a real kind of shell shock, a structural one with brain damage, and that the importance of determining and discriminating between this and functional conditions is of the greatest therapeutic significance.

There is a concussion syndrome which involves destruction of central nervous substance. I remember reading a very interesting account by a French neurologist in the first World War. He described three French soldiers leaning against a fence, apparently all within the same range of concussion from an exploding shell. The first soldier dropped dead instantly and, undoubtedly, if he had been autopsied, he would have shown many punctate hemorrhages in his brain and other parts of his central nervous system. The second soldier eventually had a so-called war neurosis, and the third took to his heels and ran like the dickens.

We spoke of sleep and the possibility of controlling sleep and lengthening sleep as a therapeutic agent.

Then Dr. Blain described and we discussed what seems to me to be a most important contribution to the psychiatry of the war, the establishment of rest houses in an informal setting without nurses, with a house mother, without the atmosphere of a hospital, but at the same time without the danger of psychological isolationism from the dangers to which the seamen had been exposed and without the likelihood of producing undue repression of their war experience.

Psychotherapy is a matter which stops at the level at which you think it wise to stop. That is all I can say in the discussion of it. There are many men whose needs will be well met by something that might smack of shallow and casual psychotherapy. It removes the symptoms and gives a little insight to go on. That is enough for that particular patient and the group that he represents. In other cases there well might be required the most profound searching of the deeper layers of the human psyche.

Of course, we stressed such things as occupational therapy and re-educational methods, all, I think, having in mind that the goal that is the ultimate salvation of a temporarily crippled man is that he get back to the sea with his defenses strengthened, perhaps even stronger than they were before he had his difficulty.

In prevention, we spoke of the importance of strengthening one

limb of the conflict, self-preservation, so that it became strong enough to dominate, for the time. These men need not feel inferior, as I fear many of them do. There are things we can do which will remove that feeling of inferiority. There are things being done. There can be a pride of service which will be equivalent to the pride of service in the Army or the Navy. There might be such things as distinctive decorations, because certainly there is no greater bravery in the Army or in the Navy or in the Air Forces than has been witnessed on the gray and lonely vastness of the sea.

One might even think in terms of the Women's Auxiliary Corps. I don't know whether you would call them the "minnows" or something else, (Laughter) but they might be indeed very helpful, helpful in boosting their morale so that the man has an honest pride in the very fine and noble thing he is doing. And then I think even the relatively small frequency of these reactions will be even less.

There are extra burdens which the man carries which are important in prevention. These men, like many men in the Army and Navy, are carrying just as much as they can carry and a little extra burden may break them. By extra burdens, I think of things that we saw so many times in the Army, a boy getting by and doing a pretty good job under difficult circumstances until he gets a "pleasant" chatty letter from a friend of his in his home town who says, "I saw your girl at the park last Sunday night with two very nice fellows." Or else he gets a letter from his wife, in which she says, "We are having a pretty tough time. We can't get by on the allotment. Most of the children are sick. I am pretty sick myself. I hope you are well and happy."

That kind of a letter is just enough to turn the scales so that one of these reactions is precipitated.

Another thing to strengthen the morale of these men who so bravely do their duty is to have them identified more closely with other branches of the service. After all, it is a very closely knit proposition. I don't mean it is possible for the seaman to get to know personally the man who is going to shoot the gun he delivers, but there can be an interchange. I would suggest that men from the Army and Navy be entertained at some of the headquarters and clubs and unions of the Merchant Marine, and vice versa; so that there is not only the theoretical but the actual understanding that we are all doing this thing together.

I want to conclude by saying anything is only as important and as sound and as intact as are its connections—the receiving station

may be perfect and splendid and the sending station likewise, but unless the connection between the two is intact and functioning smoothly, it is just as though they did not exist. So this meeting, in a sense, was devoted to making sounder, to making more intact, and to making more efficiently functioning the connection between sending and receiving in this war. And the connection between "here" and "over there" is the Merchant Marine.

Merchant seamen have been treated as step-children. If they are not too distrustful of psychiatrists I think I might offer this resolution: We hereby adopt them as the children of psychiatry.

Thank you!

TOASTMASTER PARRAN: The last speaker on our program is a man whom I have known for a number of years, ever since I have been in Washington. I think of him as representing the finest type of governmental service. Trained in sociology and an assistant professor, he rose to be an Assistant Secretary of Labor, among other positions, and now is the director of a very important division of the War Shipping Administration.

It gives me great pleasure to present to you Mr. Marshall E. Dimock.

MR. MARSHALL E. DIMOCK: Dr. Parran, Fellow Guests, Ladies and Gentlemen: Dr. Stevenson said this afternoon that the big problem of prevention is to harden seamen to a particular situation. When I heard him say that, I caught on to why it was that Dr. Blain told me I should attend as many of these sessions as possible before speaking this evening; because, of course, he had it in mind that I would have to be hardened to this particular situation.

One of the most interesting things that I have observed in Washington, and I dare say that Dr. Parran has, too, is the exclusiveness of various professional groups, which is one of the difficulties that we have in getting on in the prosecution of the war. Just before going to the War Shipping Administration, for example, I was in a lawyers' department, the Department of Justice. I am not a lawyer. I am a Ph.D. and a professor of political philosophy and public law, but not admitted to the Bar, and hence not a lawyer, and the lawyers, of course, have their own professional conceit. And so it is with every group.

As I was thinking about the problem of hardening, although that word hadn't occurred to me when I was considering this talk, I

naturally tried to determine what there is in my background and in your background which affords a common foundation for interesting you, because it was a matter of adjustment—and adjustment, I take it, is a synonym for hardening.

Incidentally, Dr. Meyer talked about the tyranny of words, and I was very much interested in that. This is the way the rationalization ran, and I must give you the rationalization because that is the way I am going to establish my rapport with you.

My first thought was that there are the pure sciences, such as chemistry and physics, and then there are the social sciences such as economics and government, which is my field, and then in between there are certain applied sciences of which medicine is one, or at least that is the layman's idea. Because, according to my observations, a good doctor is a man who understands human nature and who understands his patients and who for that reason becomes an effective practitioner. That, I should think, is particularly true in the case of psychiatrists who, after all, need to understand people if they want to get anywhere with them.

That was the first step in my logical development. The next step was that you as psychiatrists are naturally interested in security, personal security, giving a person a feeling of security, of stability. At the same time you are interested in professional freedom. I being interested in political philosophy, am interested in the same reconciliation—that is, group security—by means of economic planning and the instrumentalities of government, and also the preservation of individual freedom. Hence it occurred to me that this reconciliation of security and freedom is, in all probability, the most important problem that is going to confront us in the period after the war, and one reason I feel safe in making that assumption is because ever since people began to write political philosophy, this has been one of the recurring problems: How can you have that degree of security which affords the necessities of life to all people and at the same time provides gifted individuals or particularly skilled individuals with that degree of freedom, independence and integrity to make it possible for them to put forth their best efforts? Everybody is asking this question these days.

Everyone is saying, "How can I be a public citizen and at the same time an individualistic citizen?" Now, this takes different forms from the standpoint of vocabulary because, after all, these professional differences are primarily differences of vocabulary, but the meanings are common to all. And so what I am looking for as a basis for

establishing a relationship between us this evening is an attempt to find what is common between us by emphasizing significances or interpretations, and at the same time I am asking you to overlook my layman's vocabulary.

The impact of the war has made it inevitable that everybody should be asking this question: "How can I reconcile the demands of security with my individual desire for freedom such as we have known in the past?" And judging from what I hear at the meetings of the War Manpower Commission and read in the press, none has responded more completely than the medical profession. In comparison, discussions of group medicine, which in the last few years have been agitating your profession, shrink into relative insignificance. Every once in a while, however, physicians whom I know have some spare time and they ask themselves in a moment of reflection, "I wonder if I will be as free as I used to be; have my integrity and independence respected; have my patients choose me, or be assigned by someone else."

As I said, almost everybody in America today is asking this question in one form or another and American seaman are no exception. As has been said here several times today, the American seaman typically is fiercely individualistic. He wants his private life respected; does not like supervision or solicitousness, especially when he is ashore; demands respect for his freedom and individuality because he is equally determined to assure these same rights to everyone else. He wants security against disease, dependency, and other social hazards, but he wants them as a right, not as a charity. He wants them as a buttress to his freedom, not as a load upon it.

The government he looks upon in much the same way as do doctors and the rest of us—respects it as long as it respects him. He calls upon it for many rights and services, but insists that it keep within its appropriate sphere and not tread upon his or his group's toes. Eighty-five per cent of all American seamen belong to labor unions. So far as I can discover, seamen have the same concerns about the government's trespassing in this precinct that doctors have in their solicitude for medical practice.

All of us live by our expectancies. In our complex society all government and group behavior "rest upon and induce understandings, reactions, and conditions that operate with enough regularity to make possible some forecasting of behaviors and counterbehavior—to permit the establishment of reasonable expectancies as to what will happen if A does this or B does that." Here we find the physical

and social sciences drawing together, controlled by the same human characteristics which give rise to the basic problem of both.

Ultimately economics and statecraft resolve into a question of incentives: what makes men work, love, compete, and die? Government is based upon and essentially limited by the "way of life" of any group of people. Does not the same consideration apply in the prevention and treatment of disease, especially those of a nervous variety? As the editors of FORTUNE have recently said, in attempting to chart the new world, "We now know that the science of economics, like old J. P. Morgan's lawyer, exists not to tell us what we may do, but how and at what cost we can best do what we want to do. And what we want to do—our social aims, our national purpose—are not in the last analysis economic decisions. Such decisions must draw from deeper soil: from politics, from ethics, from religion, from the spirit of a living society."

If we were able to lay bare the truths of individual psychology, would we then be able to predict reliably the behavior of men in groups? I, for one, do not think we could, for group situations introduce a series of variables which affect and control such behavior. Such things, for example, as I, as a student of institutions, have been interested in studying what we call in my field institutional resistances.

However, it seems safe to say that certain factors are common to both your profession and mine. One of these is security; security of food, raiment, lodging, means of livelihood. Another is self-expression, and others are status, recognition, reward, incentive.

The reconciliation of security and incentive, the admixture of basic needs and room for expansion is society's oldest problem, the yardstick of many professions, including psychiatry and statecraft.

Except for purposes of classification and analysis, the distinction between individual and social psychology is practically non-existent. The individual who never associates with another is rare; individuality is a social product.

Ours has rapidly become a society in which organization and management are the keystones. The number of self employers shrinks with every generation; large corporate structures employ most of our manpower; labor bands together in aggregations, attempting to have equal bargaining power; farmers form national associations and wield unexcelled political power.

In this vast welter of organization and management, democracy must find a balancing of interests which will add up to public interest; balance one group against another so that none will have too little and none too much.

Professor Burnham has called this "The Managerial Revolution." I hope time proves him wrong and that it is merely a management age rather than a revolution, for revolution would mean the end of democratic controls over those who represent us. Of this we may be sure, though, that all interests tend to grow in size and concentration; that those who manage these aggregations increase correspondingly in power and influence; that large size tends toward standardization and the swallowing up of countless individuals' opportunities for self- expression; and that the maintenance of a statesmanlike balance taxes the ingenuity and practical ability of all who wield power. The first step in solving the problem is to secure an awareness of what the problem is and what the non-financial incentives are that must be saved. In this I assume that social and psychiatric prescriptions find another point in common.

If a man is to respond to the survival requirements of his new environment, he must understand the workings of large organization. That the medical profession is aware of this responsibility, I know from personal knowledge; for example, as long as ten years ago future hospital administrators were enrolled in my course in public administration at the University of Chicago by one of your associations, the assumption being that hospital administration is only a special aspect of the principles of large-scale management. A member of my family has just returned from the Mayo Clinic and reports that it is as smoothly and efficiently run as the best of our large corporations, blending a judicious mixture of individual consultation with clinical reports by specialists.

If security and professional freedom are to be reconciled, it must be effected within the framework of skillful administration. To some suggestions on this subject I now devote the balance of my time.

The administration of the five rest homes whose work made this conference possible may be taken as an example of democratic administration. I use them for illustrative purposes, realizing full well that after such a short period of operation we cannot reliably assess their degree of success.

The War Shipping Administration is responsible for financing

them*. Then we have entered into a contract with a private welfare organization, the United Seamen's Service, to do certain things which can probably be done better by it than by the government itself. Recreation and welfare services will be furnished by the United Seamen's Service, and that agency will also process the accounts of these projects. A line has been drawn between the business or managerial end of the operation and the medical side of the program. Both are responsible to a single official of the War Shipping Administration and work in close association, so that in reality there is a differentiation of professional function but a single responsibility for results.

The United States Public Health Service assists the War Shipping Administration in many ways, by attaching and assigning personnel, consultation, conferences of this kind—everything that has to do with the medical side, and yet throughout it respects the single line of administration and operation. Then in each area where a convalescent home is located, doctors like yourselves offer their services on a part-time basis, providing the best medical staff procurable and treating the individual cases. The labor unions are active in the program, for this is their first priority in terms of essential welfare programs, and hence they refer their members, check up on the homes, see that they are regarded as rest homes rather than "nut houses."

All of which is part of the process of keeping management democratic, counterbalancing the lopsidedness of experts in any field.

The steamship operators also come in at this point, though not so prominently. Finally, there are a host of other interested agencies which sometimes refer patients—the Red Cross, Travelers' Aid, and seamen's welfare societies. The aggregate is large but the specialized contribution of each is necessary to the total result.

Perhaps the most important points which emerge are that the medical men's professional competence is respected and considered the center of reckoning; a direct line of administrative operations is kept intact; and the interest and participation of the seamen themselves is actively solicited.

Management should be thought of as all the plans, materials and interests which are necessary to accomplish a particular design. It

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*See note at foot of page 11.

is not merely the raw bones of organization. It is more than the techniques of the trade. It is a blend of social purpose, the people to carry it out, and the organization through which it works. I emphasize this point because there is a tendency to get away from it and separate means and ends. This must never be allowed to happen. Only by keeping them together is there any hope of reconciling security and freedom, liberty and equality, specialization and opportunity for individual development. If you are one of those rare persons who finds time to read outside of your field, I suggest the last chapter on the objectives of management in a book entitled, "The Frontiers of Public Administration," by Gaus, White, and myself, written in a language which is not technical.

Management must be kept democratic as well as made efficient if there is to be any hope of reconciling public need and private expectancy. People work much harder for programs that they feel they have had a part in shaping. You men who deal constantly with the clogging and release of motive powers would find worth while reading, I believe, in Gaus' essays in the "Frontiers Book," Ordway Tead's "Art of Leadership," or Merriam's "What Is Democracy?" because I can sincerely say that I believe these books, these particular books that I am mentioning, are of as much interest to psychiatrists as to people who are called political scientists or public administrators.

Another characteristic of democratic administration is that it gives interest groups their appropriate role to fill. This has a tendency to complicate organization as well as policy decision, but that is the price we must expect to pay for the rule of the many. And it is cheaper and better in the long run. It is based upon psychological needs and expectations; it guards against imbalance; it keeps experts from going overboard; it prevents lots of mistakes. I am not trying to give you a short course, but I suggest that you might be interested in Public Administration and the Public Interest, by E. Pendleton Herring. This book, incidentally, is written by the son of a Hopkins doctor whom I knew in the days when I was attending Johns Hopkins.

There are ways of safeguarding against the confusion caused by interest representation and conflicting democratic counsel. A straight line of administrative organizations and authority can be provided, and usually should be, and if it were done more frequently,

we would be getting on with our war effort even better. This straight line of administrative functioning is described in a book by Mooney and Reilly, entitled "Principles of Organization."

Part of this process is to give everyone a clear idea of his job; not so much what he should do, but how his little role fits into the larger purpose; sell a man on the importance of what he is doing and ordinarily he will do it better. Orient him. That is not only a truth in management but it is a truth in human nature, which I should think enters also in psychiatry.

People get mixed up in large organizations as well as in their private lives. It is important, too, to bring about face-to-face relationships, whenever possible, instead of relying upon impersonal communications. This method alone puts across points of view and lays the foundation for mutual understanding. As Ordway Tead has remarked, some executives have power over people, others with them.

Basically the problems of large-scale management are psychological—much more so than structural. In reality, however, as you gentlemen know, they do not separate, because they need to be considered in conjunction.

What will become of our society if units of organization become larger and larger, specialization grows apace, and the scope for most men's egos grows more confined? Too much specialization, it is already found, disqualifies men for top executive jobs. As Dr. Parran said, let's raise our sights and look ahead. Leaders of business, government, and the professions must see broadly to keep pace with the times, must have a human appeal to lead their followers. Specialization narrows. Seniority ossifies. The result is that some corporations I know of go out to small companies for their generalists, because there they have acquired breadth and still have youth. The resulting psychological problems challenge as much as they shock us, because one of the real problems of the future is the problem of the B man, the B man who has been passed over for the A man, the A man having been recruited outside of the large hierachical organization while the B man is stopped at a certain point because he has narrowed so much that he can't possibly go to the top.

Can group security and professional freedom be reconciled in the world of tomorrow, a world of large and complex administrative units? It can be done, but it will require a lot of awareness, skill, and cooperation if it is to be done at all successfully. First, men's basic needs must be assured; until this is done retrogression is inevit-

able and people cannot well build as high as they might be able to above the superstructure of the basic level. Our plans should be decided upon after conference, representation of all parties, and with provision for universal participation. Fields of competence within the general framework should be laid out for the various professional and skill groups. Within these areas there should be self-government. Professional expectations should be assiduously safeguarded. Any man who stands out above others in any field is a man who has temperament. The extra five per cent that makes man above average because of originality and force is something which society had better not meddle with if it places a proper evaluation upon it. We in public administration have decided that the qualities which produce great executives are in the area of temperament and are at present, at least, not measurable. Genius in any field, such as medicine, I suspect, is the same kind of outcropping.

Freedom within a framework of order! Individuality within planned areas! I grant you that these reassuring catch phrases can be delusion and a snare. But nothing is impossible, if it has to be done, if there is sufficient awareness of the elements involved, and if we can produce the necessary spirit and skills to make a balanced system work.

TOASTMASTER PARRAN: Ladies and Gentlemen: There was a famous Negro evangelist, renowned far and wide for his success in holding his congregation. When he was asked the secret of it, he said, "Well you see it's like this. I takes my text and then I tells the congregation what I'se gwine to tell them, and then I tells it to them, and then I tells them what I has told them." (Laughter)

It seems to me today that we have followed that formula.

In bringing this session to a close, I can only repeat my very deep appreciation to each of you for your presence and for your contribution to its success and thank the Josiah Macy Foundation for its very generous part in it, and thank with deep appreciation the officials of the New York Academy of Medicine who have given us this very comfortable and pleasant meeting place.

Then I would not do justice if in closing I were not to tell you that the inspiration for this conference came from a rather new colleague. To him I should like to express finally the appreciation which I think all of you feel—Dr. Daniel Blain.

The meeting is adjourned.

(Adjournment at 9:35 p.m., Eastern War Time.)

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